



Board of Supervisors Health and Mental Health Cluster Agenda Review Meeting

DATE: May 13, 2026

TIME: 11:30 a.m. – 1:30 p.m.

MEETING CHAIR: Jazmine Garcia-Delgadillo, 1ST Supervisorial District

CEO MEETING FACILITATOR: Kieu-Anh King / Gustavo Medrano

THIS MEETING IS HELD UNDER THE GUIDELINES OF BOARD POLICY 3.055

To participate in the meeting in-person, the meeting location is:

Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012
Room 140

To participate in the meeting virtually, please call teleconference number:

1 (323) 776-6996 and enter the following: 330 628 704# or click here on a smartphone:

[Tel:+13237766996,,330628704#](tel:+13237766996,330628704#)

[Click here to join the meeting](#) on Microsoft Teams

For Spanish Interpretation, the Public should send emails within 48 hours in advance of the meeting to ClusterAccommodationRequest@bos.lacounty.gov

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. One (1) minute are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6 TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

- I. Call to order
- II. **Information Items (Any Information Item is subject to discussion and/or presentation at the request of two or more Board offices):**
 - a. **DHS:** Approval of Funding Methodology and Amendments to the Memorandum of Agreements Regarding Non-County Trauma Center Provisions for Reimbursement

- b. **DMH:** Approval to Extend The Existing Contract With Telecare Corporation on a Sole Source Basis for Adult Psychiatric Health Facility Services at the Martin Luther King Jr. Behavioral Health Center
- c. **DMH:** Approval to Extend the Existing Public Partnership for Wellbeing Contract with the Regents of the University of California on behalf of its Los Angeles Campus on a Sole Source Basis
- d. **DMH:** Approval to Amend Existing Legal Entity Contracts to Increase Their Maximum Contract Amounts for Fiscal Year 2025-26 for the Continuous Provision and Expansion of Specialty Mental Health Services

III. **Presentation Items:**

- a. **DPH:** Recommendation to Terminate the Declared Local Health Emergency for the January 2025 Critical Fire Events (08565)
Speakers: Muntu Davis, M.D., M.P.H., Health Officer
- b. **DMH:** Adopt the Department of Mental Health's Three Year Integrated Plan for Behavioral Health Services and Outcomes
Speakers: Kalene Gilbert-BHSA Administration, DMH; Darlesh Horn-BHSA Administration, DMH; Dr. Gary Tsai-Director, SAPC Bureau; Katherine Li-Integrated Health Initiatives, SAPC Bureau
- c. **DMH:** Adopt a Resolution to Approve the Performance Contract with the State of California, Department of Health Care Services for Fiscal Years 2026-27, 2027-28, and 2028-29
Speakers: Crystal Kibby-Board Liaison, DMH
- d. **DPH:** Authorization to Accept and Implement a Forthcoming Award and Future Awards and/or Amendments from the California Department of Public Health to Support the Childhood Lead Poisoning Prevention Program (#08627)
Speakers: Steve Baldwin, MCAH Contracts & Grants Unit Chief; Angie Toyota, CLPPP Director

IV. Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting

V. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda.

VI. Public Comment

VII. Adjournment

IF YOU WOULD LIKE TO EMAIL A COMMENT ON AN ITEM ON THE HEALTH AND MENTAL HEALTH SERVICES CLUSTER AGENDA, PLEASE USE THE FOLLOWING EMAIL AND INCLUDE THE AGENDA NUMBER YOU ARE COMMENTING ON:

HEALTH_AND_MENTAL_HEALTH_SERVICES@CEO.LACOUNTY.GOV

BOARD LETTER/MEMO CLUSTER FACT SHEET

 Board Letter

 Board Memo

 Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input checked="" type="checkbox"/> All <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Department of Health Services	
SUBJECT	Request the approval of funding methodology and allocation of funding to non-County trauma centers for Fiscal Year 2025-26, and delegation of authority to the Director of Health Services, or authorized designee, to extend the term of the Trauma Center Provisions for Reimbursement (TCPR) Memorandum of Agreement through June 30, 2026, which will contain the reimbursement provision for Fiscal Year 2025-2026, and approval of an allocation of funds to County hospitals.	
PROGRAM	Emergency Medical Services	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS	The Department of Health Care Services (DHCS) requires the County to complete the Intergovernmental Transfer by August 30, 2025, tentatively. The Trauma Centers Provisions for Reimbursement (TCPR) Memorandum of Agreements (MOA) expire June 30, 2026.	
COST & FUNDING	Total cost: \$ 73.480 million	Funding source: Measure B, Maddy Fund, Richie's Fund and federal (Ca. Dept. of Health Care Services) matching dollars for supplemental Medi-Cal payments to eligible non-County trauma centers.
	TERMS (if applicable): The amendment will extend the term of the TCPR MOAs for the period July 1, 2026 through June 30, 2027.	
	Explanation: The total maximum payment for the above-recommended actions under the MOAs for FY 2024-25 is approximately \$126.101 million, including \$73.529 million of County funds (Measure B: \$70.757 million; Maddy Fund: \$2.025 million, and Richie's Fund: \$0.747 million, which includes \$0.049 million in funds for the two County pediatric trauma hospitals) and \$52.572 million of federal matching funds, which was calculated based on a federal matching rate of 50%. Funding for the County responsible portion of the TCPR MOAs is included in DHS' FY 2024-25 Final Budget. The MOAs are fully funded by the Measure B, Maddy funds, and Richie's funds. There is no net County cost impact associated with the recommendations.	
PURPOSE OF REQUEST	Approval of the Recommendations will ratify the funding methodology and delegate authority to the Director, or designee, to execute the amendments to the TCPR MOAs, to include financial terms for FY 2025-26, extend the term of the MOAs for an additional one (1) year period, process payments for FY 2025-26, and submit an IGT to draw down federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements. These amendments permit the continued provision of Measure B funding to trauma centers which help to secure emergency care access for Medi-Cal beneficiaries, stabilize the trauma care system in Los Angeles County, and allow sufficient time for the development of a funding methodology for FY 2026-27.	

BACKGROUND (include internal/external issues that may exist including any related motions)	<p>Measure B, passed by the voters on November 5, 2002, authorized the County to levy a tax on structural improvements within the County, in part to provide funding to strengthen the Los Angeles County trauma network, particularly those trauma centers operated by the County, expand the trauma network if possible, and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system.</p> <p>The County receives funds collected from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in the County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.</p>
EQUITY INDEX OR LENS WAS UTILIZED	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Ferris Ling, Chief, Financial Management (626) 525-5800 Fling@dhs.lacounty.gov Richard Tadeo, Emergency Medical Services, Director (562) 378-1610 Rtadeo@dhs.lacounty.gov

DRAFT

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL OF FUNDING METHODOLOGY AND AMENDMENTS TO THE
MEMORANDUM OF AGREEMENTS REGARDING NON-COUNTY TRAUMA
CENTER PROVISIONS FOR REIMBURSEMENT
(ALL SUPERVISORIAL DISTRICTS) (3 VOTES)**

SUBJECT

Request for approval of a funding methodology and allocation of funding to non-County of Los Angeles (County) trauma centers for Fiscal Year (FY) 2025-26, and for delegation of authority to extend the terms of the Trauma Center Provisions for Reimbursement (TCPR) in Memorandums of Agreement (MOAs) through June 30, 2027, which will contain the reimbursement provision for FY 2025-26 and approval of an allocation of funds to County trauma centers.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve the funding methodology and allocation of the TCPR for FY 2025-26, and authorize the Director of the Department of Health Services (Director), or authorized designee, to execute amendments to the TCPR MOAs, substantially in the form attached hereto as Exhibit I, with 13 non-County trauma centers to extend the term for the period July 1, 2026 through June 30, 2027, and include the funding terms for the period July 1, 2025 through June 30, 2026, for a total County obligation of approximately \$73.480 million (comprised of \$70.757 million from Measure B funds, \$2.025 million from the Maddy Emergency Medical Services Fund (Maddy Fund), and \$0.698 million from the Richie's Fund, as set forth in Attachment A and described below);
2. Approve and authorize the Director, or authorized designee, to allocate up to a maximum of \$52.572 million of Measure B funds to be used as an Intergovernmental Transfer (IGT) to the California Department of Health

Care Services to draw down federal matching dollars for supplemental Medi-Cal payments to eligible non-County trauma centers; and

3. Approve and authorize the Director, or authorized designee, to allocate the amount of \$0.049 million from the Richie's Fund to the two County Pediatric Trauma Centers listed in Attachment A.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Funding Methodology Background

Prior to the implementation of the Affordable Care Act (ACA) in January 2014, the methodology used to distribute trauma funding to non-County trauma centers was largely based on trauma claims for the uninsured population. After the ACA was implemented and its impact became more widespread, there was a significant reduction in the volume of uninsured trauma claims. Beginning in FY 2014-15, the number of uninsured trauma claims was too minimal to allow the full allocation of Measure B funds. In light of the significant and continuing decrease in the number of uninsured, the non-County trauma centers expressed concerns and wanted to ensure they would continue to receive the same level of trauma funding as in years prior to the ACA. Therefore, on May 3, 2016, the Board approved an amendment to the Trauma Centers Agreements for FY 2014-15 which continued trauma funding to the non-County trauma centers for the same funding amounts received by the trauma centers in FY 2013-14.

Given the significant and continuing impact of the ACA, and to ensure that prior funding levels would be maintained, the non-County trauma centers deemed it necessary to develop a new basis for distributing trauma funds. Pursuant to discussions between the non-County trauma centers and the Department of Health Services (DHS), a new funding methodology for FY 2015-16 was developed that incorporated new categories for reimbursement, and which was approved by the Board on November 1, 2016.

During FY 2016-17, the non-County trauma centers advised that funding levels should be maintained at levels similar to prior fiscal years, despite the severe decline in uninsured trauma patients. As such, the funding methodology that was approved for the fiscal year was based on the following: the level of indigent services, the provision of base station services, and a flat amount to support infrastructure. In addition, and recognizing the continuing ACA impact, the non-County trauma centers identified other add-on factors to be used as a basis for the distribution of the FY 2016-17 trauma funds at levels similar to prior years. The add-ons selected by the non-County trauma centers and approved by DHS were as follows: 1) an adjustment for the volume of trauma patients; 2) an adjustment for the level of acuity of trauma patients; and 3) an adjustment for the number of Medi-Cal days and visits, which serves as a proxy for the underinsured population. Lastly,

to address concerns that the application of the proposed FY 2016-17 formula would impact each trauma center to a greater or lesser degree, a parity adjustment was made in proportion to the degree of positive or negative impact to assure that no trauma center would be affected disproportionately. The FY 2016-17 methodology was approved by the Board on May 16, 2017.

For FY 2017-18, in conjunction with all 13 non-County trauma centers, DHS reached a consensus for utilizing the basic methodology components from FY 2016-17, but with the following modifications: 1) including a parity adjustment to reduce the decrease in funding received by a trauma center in comparison to the prior fiscal year; 2) information about services was included with the Medi-Cal information given to patients who were brought in by law enforcement to determine the component related to underinsured populations; and 3) the allocation of pediatric trauma payments to each pediatric trauma center from Richie's Funds for pediatric trauma services was based on the facility type. Since Dignity Health-Northridge Hospital Medical Center is the only pediatric trauma center in the County operating as a community hospital, it was given a larger allocation than the remaining pediatric trauma centers, which are tertiary trauma centers. The FY 2017-18 methodology was approved by the Board on June 6, 2018.

DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2017-18 methodology for FY 2018-19. FY 2018-19 funding also included a one-time allocation of unspent Measure B funds from FY 2017-18 for the trauma centers as recommended by the Measure B Advisory Board (MBAB), which was presented by the Chief Executive Office (CEO) to the Board on March 12, 2019. The FY 2018-19 methodology was approved by the Board on May 21, 2019.

For FY 2019-20, DHS again reached a consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2018-19, which was presented by the CEO to the Board on February 11, 2020. The FY 2019-20 methodology was approved by the CEO on June 1, 2020, by delegated authority.

For FY 2020-21, DHS again reached a consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, but without the one-time allocation of unspent and unallocated Measure B funds, as recommended by the MBAB. The FY 2020-21 methodology was approved by the Board on June 22, 2021.

For FY 2021-22, DHS again reached a consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2020-21, which was presented by the CEO to the Board on

February 7, 2022. The FY 2021-22 methodology was approved by the Board on June 14, 2022.

For FY 2022-23, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2021-22 methodology for FY 2022-23 with the following modifications: 1) no parity adjustment to mitigate the change in funding received by a trauma center in comparison to the prior fiscal year and the one-time allocation of unspent and unallocated Measure B funds, per recommendation by the MBAB; and 2) an annual ongoing Measure B funding of \$8.957 million per the Measure B property assessment rate increase, which the Board approved on September 13, 2022. Of this amount, \$5.957 million was allocated to all 13 non-County trauma centers to support ongoing investments to maintain and/or expand the regional trauma care system, while \$3.000 million was allocated to five pediatric trauma hospitals to support ongoing investments in pediatric trauma care. The FY 2022-23 methodology was approved by the Board on June 6, 2023.

For FY 2023-24, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2022-23 methodology. FY 2023-24 funding also included a one-time allocation of unspent Measure B funds for the trauma centers as recommended by the MBAB, which was presented by the CEO to the Board on January 24, 2024. The FY 2023-24 methodology was approved by the Board on June 4, 2024.

For FY 2024-25, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2023-24 methodology, without any approved MBAB projects which would use unspent and unallocated Measure B funds. The FY 2024-25 methodology was approved by the Board on June 10, 2025.

FY 2025-26 Distribution Methodology

For FY 2025-26, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2024-25 methodology with the modification of additional ongoing Measure B funding of \$14.942 million per the FY 2025-26 Measure B property assessment rate increase, which the Board approved on July 15, 2025. This amount was allocated to all 13 non-County trauma centers to support ongoing investments to maintain and/or expand the regional trauma care system.

The proposed FY 2025-26 payments to each non-County trauma center are summarized in Attachment A.

TCPR MOA Background

Prior to June 30, 2021, the trauma center designation process requirements, and provisions for reimbursement were covered under a Trauma Center Services Agreement as a means to provide supplemental funding to offset operating expenses related to trauma center operations. On June 22, 2021, DHS split the two actions and executed TCPR MOAs for the continued implementation of reimbursement provisions for designated trauma centers. The trauma center designation for each hospital was added, by way of an amendment, and under delegated authority by the Board, to the Specialty Care Center Designations Master Agreement, which was approved by the Board on June 11, 2019.

Summary of Recommendations

Approval of the recommendations will ratify the funding methodology and delegate authority to the Director, or authorized designee, to execute amendments to the TCPR MOAs, substantially in the form attached hereto as Exhibit I, to include financial terms for FY 2025-26, extend the term of the MOAs for an additional one (1) year period, process payments for FY 2025-26, and submit an IGT to draw down federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements. These amendments permit the continued provision of Measure B funding to trauma centers which help to secure emergency care access for Medi-Cal beneficiaries, stabilize the trauma care system in the County, and allow sufficient time for the development of a funding methodology for FY 2026-27.

Implementation of Strategic Plan Goals

These recommendations support the County Strategic Plans: North Star 3, Goal G, Strategy i., "Maximize Revenue"; North Star 3, Goal A, Strategy i., "Customer Service"; and North Star 1, Goal A, Strategy ii., "Improve Health Outcomes".

FISCAL IMPACT/FINANCING

The total maximum payment for the above-recommended actions under the MOAs for FY 2025-26 is approximately \$126.052 million, including \$73.480 million of County funds (Measure B: \$70.757 million; Maddy Fund: \$2.025 million, and Richie's Fund: \$0.747 million, which includes \$0.049 million in funds for the two County pediatric trauma hospitals) and \$52.572 million of federal matching funds, which was calculated based on a federal matching rate of 50%. Funding for the County's portion of the TCPR MOAs is included in DHS' FY 2025-26 Final Budget. The MOAs are fully funded by Measure B, Maddy funds, and Richie's funds. There is no net County cost impact associated with the recommendations.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Pursuant to the authority under California Health and Safety (H&S) Code Section 1798.160 et seq., the County maintains trauma facilities as part of a regional trauma care system for the treatment of potentially seriously injured persons. Division 2.5 of the H&S Code authorizes the local Emergency Medical Services Agency to designate trauma centers as part of the regional trauma care system. Since March 1, 2017, there have been 13 non-County and two County-operated trauma centers.

The TCPR MOAs are designed to provide supplemental funding to offset the significant expenses related to maintaining a trauma designation and treating trauma patients. The FY 2025-26 TCPR MOAs are funded by Measure B, Maddy Fund, and Richie's funds and contemplate the State making IGT-funded supplemental Medi-Cal payments to non-public trauma centers in the County.

Measure B Funds

Measure B, passed by the voters on November 5, 2002, authorized the County to levy a tax on structural improvements within the County, in part to provide funding to strengthen the County trauma network, particularly those trauma centers operated by the County, expand the trauma network if possible, and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system.

The Maddy and Richie's Funds

The County receives funds collected from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in the County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.

Medi-Cal Payments

The California State Plan, starting at page 51 of Attachment 4.19B, permits the California Department of Health Care Services to make supplemental Medi-Cal payments to non-public trauma centers in the County. The County makes

recommendations regarding the amount of the supplemental payments and provides the funding for the non-federal share of such payments through an IGT.

County Counsel has reviewed and approved Exhibit I as to its form.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will ensure continued participation of non-County trauma centers in the County's trauma system and provide trauma funding for FY 2026-27.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:ad

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

**COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
LOS ANGELES COUNTY TRAUMA CARE SYSTEM**

**PROPOSED PAYMENTS TO NON-COUNTY TRUAMA HOSPITALS
FISCAL YEAR 2025-26**

Attachment A

Patient-Based (1)	Pediatric (2)	Designation Support		Add-Ons			Additional Ongoing Funding for Measure B Rate Increases			Total Payments (1) thru (10)	
		(3)	(4)	(5)	(6)	(7)	Board Approved 9/13/2022 (8)	PEDIATRIC HOSPITAL (9)	Board Approved 7/15/2025 (10)		
UNINSURED (Volume)	PEDIATRIC (Fixed Rate)	BASE STATION (Fixed Rate)	INFRASTRUCTURE (Fixed Rate)	TRAUMA (Volume)	ACUITY (Adjustment)	UNDERINSURED (Adjustment)	TRAUMA HOSPITALS (Adjustment)	PEDIATRIC HOSPITAL (Adjustment)	ALL HOSPITALS (Adjustment)		
Non-County Hospitals											
Antelope Valley Hospital	\$ 216,402	\$ -	\$ 700,000	\$ 1,200,000	\$ 1,317,400	\$ 583,554	\$ 2,547,262	\$ 814,324	\$ -	\$ 2,042,576	\$ 9,421,518
California Hospital Medical Center - Dignity Health	2,423,608	-	700,000	1,200,000	1,920,912	1,026,374	5,525,182	1,587,320	-	3,981,488	18,364,884
Cedars-Sinai Medical Center	70,730	24,419	700,000	1,200,000	1,458,932	784,842	2,043,700	776,314	393,980	1,947,236	9,400,153
Children's Hospital Los Angeles	-	24,419	-	1,200,000	374,747	106,409	400,243	258,192	1,945,338	647,626	4,956,974
Henry Mayo Newhall Hospital	-	-	700,000	1,200,000	657,810	262,336	760,413	444,158	-	1,114,088	5,138,805
Huntington Hospital	-	-	700,000	1,200,000	1,635,484	553,430	1,045,749	624,536	-	1,566,632	7,225,731
Long Beach Medical Center - MemorialCare	57,260	24,419	700,000	1,200,000	1,481,185	567,532	1,944,725	738,168	1,492,722	1,851,556	10,057,567
Northridge Hospital Medical Center - Dignity Health	1,479,982	600,000	700,000	1,200,000	1,561,297	509,824	2,119,982	939,174	971,736	2,355,736	12,437,731
Pomona Valley Hospital Medical Center	639,898	-	700,000	1,200,000	1,476,735	702,007	2,287,515	869,096	-	2,179,960	10,055,211
Providence Holy Cross Medical Center	2,237,170	-	700,000	1,200,000	1,269,333	482,505	2,037,423	983,252	-	2,466,302	11,375,985
Ronald Reagan UCLA Medical Center	96,270	24,419	700,000	1,200,000	1,288,916	625,122	1,990,109	731,932	598,112	1,835,910	9,090,790
St. Francis Medical Center	170,924	-	700,000	1,200,000	1,545,275	668,340	3,269,050	937,002	-	2,350,294	10,840,885
St. Mary Medical Center - Dignity Health	795,714	-	700,000	1,200,000	872,333	361,258	1,425,713	664,276	-	1,666,210	7,685,504
Subtotal Non-County Hospitals	\$ 8,187,958	\$ 697,676	\$ 8,400,000	\$ 15,600,000	\$ 16,760,359	\$ 7,233,533	\$ 27,397,066	\$ 10,367,744	\$ 5,401,888	\$ 26,005,514	\$ 126,051,738
County Hospitals											
Los Angeles General Medical Center	\$ -	\$ 24,419	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 24,419
Harbor-UCLA Medical Center	-	24,419	-	-	-	-	-	-	-	-	24,419
Subtotal County Hospitals	\$ -	\$ 48,838	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 48,838
Grand Total:	\$ 8,187,958	\$ 746,514	\$ 8,400,000	\$ 15,600,000	\$ 16,760,359	\$ 7,233,533	\$ 27,397,066	\$ 10,367,744	\$ 5,401,888	\$ 26,005,514	\$ 126,100,576

- Col (1) - Payment is based on each hospital's share in the total value of the FY 2024-25 indigent claims submitted by non-County trauma hospitals to the County (net of FY 2023-24 disallowed claims), multiplied by the total funding allocated for this category.
- Col (2) - Payment is based on facility type. Northridge Hospital Medical Center receives a larger allocation due to its State-designated status as a Pediatric Community Hospital.
- Col (3) - Fixed payment for each hospital that provides base hospital service meeting the requirement of County's Emergency Medical Services Agency.
- Col (4) - Infrastructure is a fixed payment for each trauma hospital to defray the trauma call panel, specialist physicians and trauma program costs.
- Col (5) - Trauma payment is based on each hospital's percentage in the total trauma patient volume of non-County trauma hospitals (reported by County's TEMIS for CY 2024) multiplied by the total funding allocated for this category.
- Col (6) - Acuity payment is based on each hospital's percentage in the total patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2024) that are adjusted for severity factors, multiplied by the total funding allocated for this category.
- Col (7) - Underinsured payment is based on each hospital's percentage in the total Medi-Cal and In-Custody patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2024), multiplied by the total funding allocated for this category.
- Col (8) - Payment is based on each hospital's percentage of the grand total from columns 1 - 7 (except column 2) for each hospital, multiplied by \$5.957 million, then distributed so that the two public hospitals (Antelope Valley Hospital and Ronald Reagan UCLA Medical Center) receive funding directly from the County in amounts equivalent to the amounts they would have received if they were eligible for State matching.
- Col (9) - Payment is based on a similar calculation with columns 5, 6 and 7, but using only pediatric data.
- Col (10) - Payment is based on each hospital's percentage of the grand total from columns 1 - 7 (except column 2) for each hospital, multiplied by \$14.942 million, then distributed so that the two public hospitals (Antelope Valley Hospital and Ronald Reagan UCLA Medical Center) receive funding directly from the County in amounts equivalent to the amounts they would have received if they were eligible for State matching.

Agreement No. _____

MEMORANDUM OF AGREEMENT
BY AND BETWEEN COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
AND
Contractor
FOR
NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT
AMENDMENT NO. 5

This AMENDMENT NO. _ (the "Amendment") is made and entered into this ___ day of _____, 2026, (hereinafter "Amendment Effective Date") by and between the County of Los Angeles (hereinafter "County") and Contractor, located at address XX (hereinafter "Contractor" and, together with County, the "Parties").

WHEREAS, County and Contractor entered into that certain Memorandum of Agreement No. _____ for Non-County Trauma Center Provisions for Reimbursement, dated _____, including any amendments and other modifications thereto (collectively hereinafter referred to as "MOU"); and

WHEREAS, on June __, 2026,, the Board of Supervisors (hereinafter "Board") delegated authority to the Director of County's Department of Health Services (hereinafter "DHS"), or authorized designee, to execute amendments to the MOA to extend the term of the MOA for the period July 1, 2026 through June 30, 2027, to provide for a funding allocation for Fiscal Year 2025-26, for a total County obligation of approximately \$73.48 million comprised of various amounts from Measure B, the Maddy Emergency Medical Services Fund (the "Maddy Fund"), and Richie's Fund.

WHEREAS, Paragraph [6.0] (governing amendments) of the MOU provides that changes to the MOU shall be made in the form of an amendment to be approved and executed by the Parties; and

WHEREAS, the Contractor warrants that it continues to possess the competence, expertise and personnel necessary to provide services consistent with the requirements of the MOU and consistent with the professional standard of care for these services.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. Following execution, this Amendment is effective the Amendment Effective Date.

2. Capitalized terms used and not defined in this Amendment have the respective meanings assigned to them in the MOU.
3. Paragraph 1.0 – SCOPE of the MOU is deleted in its entirety and replaced to read as follows:

“1.0 SCOPE

1.1 This MOA addresses funding through the fiscal year ending June 30, 2026 (the “Contract Period”) for non-County trauma hospitals in Los Angeles County having trauma centers (“Non-County Trauma Hospitals”). Non-County Trauma Hospitals are hospitals that are not owned nor operated by the County of Los Angeles (the “County”). The County’s funding to Non-County Trauma Hospitals for this Contract Period is intended to ensure the continuance of emergency care access for Medi-Cal beneficiaries and to stabilize the provision of trauma care services in Los Angeles County.

1.2 The funding identified in this MOA for Non-County Trauma Hospitals, described in Exhibit A, Provisions For Reimbursement, covers the following four components:

1.2.1. Patient/Hospital-Based Payments

This component includes uninsured trauma claims and pediatric trauma services, as described in Exhibit A, Sections I and II.

1.2.2 Designation Support Payments

This component includes payments for Non-County Trauma Hospitals that serve as base stations and funding for trauma hospitals' infrastructure, as described in Exhibit A, Section III A.

1.2.3 Add-On Payments

This component includes payments for: a) trauma patient volume; b) patient acuity; c) the volume of underinsured patients (i.e., Medi-Cal and In-Custody patients); and d) a parity adjustment to mitigate the negative financial impact among various hospitals as described in Exhibit A, Section IV.

1.2.4 Measure B Advisory Board Funding (if available)

This component includes one-time payments, as applicable, if funding is available and recommended by the Measure B Advisory Board (MBAB), and approved by the County Board of Supervisors, to distribute prior year unspent and unallocated Measure B funds as described in Exhibit A, Section V.

- 1.3 The County intends to provide funding to Hospital for one or more of the four components described in Section 1.2 from the following fund sources under this MOA: Measure B, the Maddy Fund, and Richie's Fund. In addition, the County will utilize Measure B funds, to the extent possible, to make an inter-governmental transfer (IGT) of funds to the California Department of Health Care Services (CDHCS) to draw down Federal matching dollars for enhanced Medi-Cal payments to Eligible Trauma Hospitals, pursuant to California's Medicaid State Plan (Title XIX), Attachment 4.19B (governing enhanced payments to private trauma hospitals), pp. 51-51c (TN-03-032, app. Mar. 31, 2005; eff. Jul. 1, 2003), attached hereto as Attachment A.
- 1.4 Hospital acknowledges that Attachment A was approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Attachment A enables private trauma hospitals in Los Angeles County to receive additional Medi-Cal payments, under Section 14087.3 of the California Welfare and Institutions Code. Pursuant to Medicaid State Plan and a related interagency agreement between the County and the CDHCS, these additional Medi-Cal payments are distributed to County-designated private trauma hospitals in a lump-sum amount to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County."
4. Paragraph 2.0 – TERM of the MOU is deleted in its entirety and replaced to read as follows:
- “2.0 TERM
- 2.1 The term of this MOA is effective upon the date of execution by the Director of Health Services (Director), or designee. This MOA shall expire on June 30, 2026, unless sooner extended or terminated, in whole or in part, as provided herein.
- 2.2 In any event, this MOA may be terminated for any reason at any time by either party by giving at least thirty (30) calendar days advance written notice to the other party.”
5. Paragraph 3.0 – PAYMENT AND INVOICES of the MOU is deleted in its entirety and replaced to read as follows:
- “3.0 PAYMENT AND INVOICES
- 3.1 County's maximum reimbursement amount to the Non-County Trauma Hospitals for the delivery of trauma services for fiscal

years 2020-21, 2021-22, 2022-23, 2023-24, 2024-25 and 2026-27 shall not exceed the amounts identified in Exhibit A.”

6. Exhibit A – Provisions For Reimbursement attached to the MOU is modified by adding Exhibit A-5, attached hereto and incorporated herein by reference, to the existing Exhibits A, A-1, A-2, A-3 and A-4. Any reference to Exhibit A in the MOA shall include Exhibit A-5.
7. Except as expressly provided in this Amendment, all of the terms and provisions of the MOU are and will remain in full force and effect and are hereby ratified and confirmed by the Parties. Without limiting the generality of the foregoing, the amendments contained herein will not be construed as an amendment to or waiver of any other provision of the MOU or as a waiver of or consent to any further or future action on the part of either Party that would require the waiver or consent of the other Party. On and after the Amendment Effective Date, each reference in the MOU to "this Agreement," "the Agreement," "the MOA," "hereunder," "hereof," "herein" or words of like import will mean and be a reference to the MOU as amended by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the Director of Health Services, or authorized designee, and Contractor has caused this Amendment to be executed on its behalf by its duly authorized officer(s), on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By: _____ for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

By: _____
Signature

Printed Name

Title

APPROVED AS TO FORM
DAWYN R. HARRISON
COUNTY COUNSEL

By: _____
James Chow
Senior Deputy County Counsel

EXHIBIT A-5
PROVISIONS FOR REIMBURSEMENT
ATTACHED TO AMENDMENT NO.
TO
MEMORANDUM OF AGREEMENT (MOA)

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LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1	PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM
2	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE – ENGLISH
3	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE – SPANISH
4	TRAUMA SERVICES COUNTY ELIGIBILITY (TSCE)
5	HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE
6-6.8	INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION
7	TRAUMA CENTER PAYMENT SURRENDER FORM

TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE PATIENT-BASED FUNDING

A. BUDGET ALLOCATION

1. Patient-Based Allocation Amounts

This Section I is applicable to the Non-County Trauma Hospitals with the exception of Children’s Hospital Los Angeles. For the Contract Period, the County has established a budget allocation (the “Budget Allocation”) for each such Non-County Trauma Hospital providing medical care to Eligible Patients (as defined below) during the Contract Period. The budget allocations are as follows:

Antelope Valley Hospital	\$ 216,402
Dignity Health-California Hospital Medical Center	\$ 2,423,608
Cedars-Sinai Medical Center	\$ 70,730
MemorialCare Long Beach Medical Center	\$ 57,260
Dignity Health-Northridge Hospital Medical Center	\$ 1,479,982
Pomona Valley Hospital Medical Center	\$ 639,898
Providence Holy Cross Medical Center	\$ 2,237,170
Ronald Reagan UCLA Medical Center	\$ 96,270
St. Francis Medical Center	\$ 170,924
Dignity Health-St. Mary Medical Center	<u>\$ 795,714</u>
Total Patient Based Funding	\$ 8,187,958

The above amounts for each hospital were determined based on each Non-County Trauma Hospital’s share of the total value of the Fiscal Year (FY) 2024-25 indigent claims submitted by all the Non-County Trauma Hospitals to the County, net of any FY 2023-24 disallowed claims, multiplied by the total funding allocated for this category (which include Measure B, Maddy, and federal matching funds). The value of the indigent claims was computed by applying the emergency department (ED) visit or per diem rates

described in the paragraph below. The final value of all the claims was adjusted upwards by an escalation factor of 122.80%, in order to fully distribute the entire funding available for this category. Payments to Non-County Trauma Hospitals listed in this section will be made directly by the County (inclusive of the Maddy Fund as defined below) and/or by the California Department of Health Care Services (CDHCS) as enhanced Medi-Cal payments to eligible private hospitals as set forth in this Exhibit.

\$ 6,425 per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)

\$12,471 for the first inpatient day; and

\$ 5,417 for the second inpatient day; and

\$ 4,283 for the third inpatient day; and

\$ 4,283 for the fourth inpatient day; and

\$ 3,023 for each day thereafter.

Accordingly, the Patient-Based Allocations will be taken into account in the amounts that the County recommends be paid by CDHCS as enhanced Medi-Cal payments taking into account direct payments the County has made or will make to the hospitals for such allocations.

2. Maddy Fund

Certain funding known as “Maddy Emergency Medical Services Fund” (Maddy Fund) is available for hospital care rendered to Eligible Patients (as defined in I.B below) by the Non-County Trauma Hospitals. As described in I.D of this Exhibit, Contractor is required to submit a claim (an “Eligible Claim”) to the County for the hospital care rendered to Eligible Patients within the Contract Period. Based on claims for patient visits and days from July 1, 2024, to June 30, 2025, County will determine the Maddy Fund payment amount for ED visits, and inpatient stays up to three (3) days, using the rates below plus an escalation adjustment factor of 122.80%, due to

each hospital for this Contract Period. The amount of Maddy Fund payments is included in determining the total funding for the Patient/Hospital-Based Allocation amount.

\$ 6,425 per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)

\$12,471 for the first inpatient day; and

\$ 5,417 for the second inpatient day; and

\$ 4,283 for the third inpatient day.

B. GENERAL CONDITIONS

Contractor shall provide Trauma Services, as defined below, to Eligible Patients. For purposes of this Exhibit, an "Eligible Patient" is a patient receiving Trauma Services from Contractor meeting the following criteria: (1) the Contractor believes that the patient is unable to pay for the Trauma Services so provided; (2) the patient has no third-party coverage, in part or in whole for the Trauma Services provided by Contractor and (3) the patient's annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

For purposes of this Exhibit, "third-party coverage" or "third-party payers" includes but is not limited to commercial insurance or any program funded in whole or in part by local, state, or federal government. "Trauma Services" refers to all hospital services furnished by the Contractor to a patient who presents to the Contractor or is classified subsequently during the patient's stay as a Trauma Patient from the time the patient presents at or is admitted to the Contractor's hospital until the patient is discharged. The term "Trauma Patient" for purposes of this Contract is defined in the Specialty Care Center Designation Master Agreement Exhibit A, Sub Exhibit - TC Trauma Center, Attachment 5, *Patient Inclusion in the Trauma Data System* and incorporated in this Exhibit as Attachment 1.

A claim (a "Patient-Based Claim") shall not be submitted to the County hereunder for an Eligible Patient if: (a) the patient has the ability to pay for the service but refuses or fails to pay for the service; or (b) Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s); or (c) for any Trauma Services which is covered in, or the subject of reimbursement in, any other contract between Contractor and County. Subject to the County's review and verification, Contractor will determine and document persons who are Eligible Patients as described in Section I.C below.

A County claim is accepted from Non-County Trauma Hospitals for patient care provided to Trauma Patients who do not have the ability to pay for the services under the following conditions: (1) Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, in accordance with Section I.C below; (2) Contractor either determines that (a) there is no source of payment, or (b) there is a potential source of payment, but the Contractor is unable to obtain payment after making reasonable efforts to pursue such revenue; and (3) the patient's annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code (W&IC), Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice of the availability of reduced cost hospital care. Additionally, Contractor shall post, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced-cost hospital care. The approved "Notice" language is reflected in English in Attachment 2 and in Spanish in Attachment 3.

C. PATIENT ELIGIBILITY

For a patient to be an Eligible Patient, Contractor must document that the person cannot afford to pay for the services provided by the Contractor. Contractor must also document that payment for the services will not be covered by third-party

coverage, including any program funded in whole or in part by the federal government, and that Contractor has not received payment for any portion of the amount billed.

The documentation that the person cannot afford to pay must show that the patient's annual income places the patient at or below 200% of the current year's Federal Poverty Level (FPL).

Contractor shall utilize Attachment 4, *Trauma Service County Eligibility* ("TSCE") *Agreement* form as the sole means for determining whether the patient is at or below the 200% of the current year FPL and therefore meets patient's eligibility criteria for trauma care claiming during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s) at the time it is determined there is not a responsible private or public third-party source of payment and that the patient meets the eligibility requirements. The completed form must be signed and dated by the hospital representative who obtained the information, verifying that the information was obtained from the patient or the patient's responsible relative(s).

If a TSCE Agreement form cannot be secured because the patient's condition prevents the patient from providing the necessary financial information, and there is no responsible relative(s) available, then Attachment 5, *Hospital Certification of Inability to Cooperate* form must be completed. A hospital representative will complete the form, sign and date it, and a second hospital representative will verify the information by also signing and dating the form. The original (or electronic scan) of either the *TSCE* or *Inability to Cooperate* form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the application form to the County Emergency Medical Services (EMS) Agency when submitting a claim to be included in the patient-based claims total as stated in Attachment 6, *Instructions for Submission of Claims and Data Collection*.

Contractor must document that it has made reasonable efforts to secure payment from the patient by billing upon discharge and two (2) subsequent billings at least a month apart with a minimum of three (3) billings. Financial notes must clearly indicate that the patient was billed at least three (3) times.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request to authorized County or State representatives for inspection, audit, and photocopying.

D. CLAIMS SUBMISSION

Contractor shall submit all Patient-based Claims to the County for Trauma Services to Eligible Patients for the Contract Period. These claims, subject to the following conditions and subsequent agreements of the parties, will be used to determine the amount of the patient-based Budget Allocation for Contractor. Claims from the prior fiscal year will be used to determine the patient-based funding for the contract period.

1. A valid claim shall include a completed Trauma Patient Summary (“TPS”) form for each Eligible Patient receiving Trauma Services.
2. In addition to the TPS form, Contractor shall submit the required claim form (UB04) as well as all required reports as set forth in Attachment 6, *Instructions for Submission of Claims and Data Collection*, attached hereto and incorporated herein by reference, to County’s Emergency Medical Services Agency, 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, California 90670, for Trauma Services provided to Eligible Patients under the terms of this Agreement. This information shall be used in determining the next (and possibly subsequent) year’s Budget Allocation.
3. Claims submitted to the County shall be limited to the hospital component of Trauma Services provided to Eligible Patients during the term of this Agreement. Inclusion of the claims in the determination of a Contractor’s Budget Allocation or funding under

this Agreement shall be limited to the claims for which all required data has been included in the Trauma and Emergency Medicine Information System (TEMIS) and which has been submitted as required by reporting procedures reflected in Attachment 6.

4. Claims shall be submitted to County's EMS Agency on an ongoing basis once all eligibility requirements have been met and the Contractor has determined that no other source of funding is likely to be available. All Contractor claims for services provided during a County Fiscal Year (FY) (July 1 – June 30) must be received by County no later than the last working day of the first December following the close of the FY. Only claims for which the Contractor has ascertained that no payment will be received should be submitted.
5. To the extent permitted by law, upon submission of claim by Contractor to County for a trauma patient's care, and unless and until the claim is rejected by the County, Contractor assigns and subrogates to County any and all rights to collection as set forth herein, and Contractor shall cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from the patient. At its sole discretion, County and/or County's contractor may proceed independently against any parties responsible for payment for the Trauma Services to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees (including, for example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCPR, but only to the extent permitted by law. In the event Contractor is contacted by a third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation concerning a claim that has been assigned to the County hereunder, Contractor shall indicate that the claim is assigned and subrogated to the County and refer

such representative to the designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

6. Contractor shall notify the County and update the financial status of the patient in TEMIS if Contractor becomes aware of any third-party coverage such as Medi-Cal, Medicare, other government programs, or other health insurance for any claim that the Contractor submitted to be included for purposes of calculating the Budget Allocation. The County reserves its right to work with the identified third-party payers to receive any payment due with respect to claims that Contractor has assigned to County, but only to the extent permitted by law.
7. Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County, and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment that was received within sixty (60) days of receipt of such payment and must complete and submit Attachment 7, TRAUMA CENTER PAYMENT SURRENDER FORM, with each surrendered payment.
8. For Trauma Patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement and remaining in the hospital after that date, reports and claim submission to County shall be made only after the patient has been discharged; the Contractor shall not submit partial or interim billings.
9. All reports and claims shall be completed in such detail and with such attachments to comply with the procedures prescribed in Attachment 6. Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Contractor and County agree that County may from time to time revise such forms, and such procedures and instructions without need for a formal amendment to this Agreement. Such revised forms, procedures and instructions

shall be effective fifteen (15) calendar days after written notice to Contractor. In the event Contractor submits a timely written objection, Contractor and County will promptly meet and confer in good faith in an effort to resolve their differences. In the event the parties are not able to resolve their differences, Contractor may send a written notice to County within (30) days of the meet and confer session terminating this Agreement. This Agreement shall terminate fifteen (15) days after the date of the written notice or on such other day as the parties shall agree in writing.

E. AUDITING OF RECORDS

Contractor shall maintain and, upon request, make available to State or County representatives, records containing the financial information referenced in this Section, including records of patient and third-party payer payments, all in accordance with Section I.B. (governing general conditions) of this Exhibit.

1. County may periodically conduct an audit of the Contractor's records pertaining to the Patient-Based Claims for Eligible Patients that are required under this Exhibit. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of submitted claims for a fiscal year, provided the sampling methodology is statistically valid. The scope of the audit shall include an examination of patient medical and financial records, patient and/or insurance billing records, and collection agency reports associated with the sampled claims.
2. Audited claims that do not comply with requirements in this Agreement shall result in a reduction in the total value of patient-based claims that will be used to determine each trauma hospital's patient-based Budget Allocation for the next fiscal year. For example, if two patient-based claims for the prior fiscal year with a total value of \$12,850 were audited and determined not to be in compliance with the program requirements and the Contractor's total

value of submitted claims for that prior fiscal year was \$150,000, \$12,850 would be subtracted from the total value, reducing it to \$137,150 which would then be the amount used to determine the Contractor's patient-based Budget Allocation for the next fiscal year. The County will notify Contractor of any audit findings. Audit results may be appealed to the EMS Agency Director, or his/her designee.

II. FUNDING FOR PEDIATRIC TRAUMA CENTERS

The parties acknowledge that Section 76000.5 of the California Government Code authorizes the County Board of Supervisors (Board) to elect to levy an additional penalty in the amount of two dollars (\$2) for every ten dollars (\$10), upon fines, penalties, and forfeitures collected for certain criminal offenses. Section 76000.5 remains in effect through January 1, 2027.

California Health and Safety Code section 1797.98a, subdivision (e) (known as Richie's Fund) authorizes the Board to utilize fifteen percent (15%) of the funds collected to provide funding for pediatric trauma centers (PTCs) throughout the County, both publicly and privately owned and operated.

The FY 2024-25 Richie's Fund collections available for FY 2025-26 allocation to the non-County PTCs and County PTCs are \$746,514. This amount is allocated to PTCs for the expansion of pediatric trauma care services as follows:

Cedars-Sinai Medical Center	\$ 24,419
Children's Hospital Los Angeles	\$ 24,419
MemorialCare Long Beach Medical Center	\$ 24,419
Dignity Health-Northridge Hospital Medical Center	\$600,000
Ronald Reagan UCLA Medical Center	<u>\$ 24,419</u>
Total	\$697,676

III. DESIGNATION SUPPORT FUNDING

The funding described in this Section III is in addition to the funding described in

Sections I and II of this Exhibit.

A. BASE HOSPITAL SERVICES AND INFRASTRUCTURE

To account for the special costs incurred for those private trauma hospitals providing base and trauma hospital services and to ensure the continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients to the most appropriate emergency room, the County will recommend to the State that it make an aggregate supplemental payment in the amount of \$700,000 for base station and \$1,200,000 for infrastructure to each private Non-County Trauma Hospital pursuant to the Trauma SPA, with the exception of Children's Hospital Los Angeles. Children's Hospital Los Angeles will receive a supplemental infrastructure payment in the amount of \$1,200,000 but will not receive a supplemental base station payment because it does not provide base hospital services.

As public hospitals, Ronald Reagan UCLA Medical Center ("UCLA") and Antelope Valley Hospital ("Antelope") may not receive these supplemental Medi-Cal payments under the State Plan. Accordingly, the County will directly pay each of those hospitals the amount of \$700,000 for base station support and \$1,200,000 for infrastructure support at or about the same time as County makes its IGT payment to the State. In the event the County makes its IGT payment to the State in multiple installments, the County will make the base station and infrastructure supplemental payments to UCLA and Antelope in the same number of installments.

IV. ADD-ONS PAYMENTS

The funding described in this Section IV is in addition to the funding described in Sections I, II and III of this Exhibit. The total payment amounts below were designed to reflect the following: a) trauma patient volume; b) trauma patient acuity; and c) the levels of underinsured trauma patients treated.

Antelope Valley Hospital	\$ 4,448,216
Dignity Health-California Hospital Medical Center	\$ 8,472,468
Cedars-Sinai Medical Center	\$ 4,287,474
Children's Hospital Los Angeles	\$ 881,399
Henry Mayo Newhall Hospital	\$ 1,680,559
Huntington Hospital	\$ 3,134,663
Memorial Care Long Beach Medical Center	\$ 3,993,442
Dignity Health-Northridge Hospital Medical Center	\$ 4,191,103
Pomona Valley Hospital Medical Center	\$ 4,466,257
Providence Holy Cross Medical Center	\$ 3,789,261
Ronald Reagan UCLA Medical Center	\$ 3,904,147
St. Francis Medical Center	\$ 5,482,665
Dignity Health-St. Mary Medical Center	<u>\$ 2,659,304</u>
Total	\$51,390,958

Except for UCLA and Antelope, it is the intent of the County to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA and Antelope to support their provision of trauma services.

V. ADDITIONAL FUNDING FROM MEASURE B TAX RATE INCREASE

The funding described in this Section V is in addition to the funding described in Sections I, II, III and IV of this Exhibit. On September 13, 2022, the Board of Supervisors approved an increase to the Measure B Trauma, Emergency, and Bioterrorism Response property assessment rate of \$0.0076 per improved square foot, for a total assessment of \$0.0500 per improved square foot, effective July 1, 2022. Of the additional revenue collected, the Board approved granting \$5.96 million of the annual ongoing revenue to the thirteen (13) non-County Trauma Hospitals to support staffing, technology, and capital improvement investments to maintain or expand the regional trauma care system, as well as \$3.00 million per year to five (5) non-County Pediatric Trauma Hospitals for investments in staffing,

technology, and capital improvements to boost pediatric trauma care.

1. The total payments of \$10.37 million, including \$5.96 million from Measure B dollars and \$4.41 million in federal matching dollars for enhanced Medi-Cal payments, to the thirteen (13) Non-County Trauma Hospitals are as follows:

Additional Funding to Support Trauma Care System

Antelope Valley Hospital	\$ 814,324
Dignity Health-California Hospital Medical Center	\$ 1,587,320
Cedars-Sinai Medical Center	\$ 776,314
Children’s Hospital Los Angeles	\$ 258,192
Henry Mayo Newhall Hospital	\$ 444,158
Huntington Hospital	\$ 624,536
MemorialCare Long Beach Medical Center	\$ 738,168
Dignity Health-Northridge Hospital Medical Center	\$ 939,174
Pomona Valley Hospital Medical Center	\$ 869,096
Providence Holy Cross Medical Center	\$ 983,252
Ronald Reagan UCLA Medical Center	\$ 731,932
St. Francis Medical Center	\$ 937,002
Dignity Health-St. Mary Medical Center	<u>\$ 664,276</u>
Total	\$ 10,367,744

2. The total payments of \$5.40 million, including \$3.00 million from Measure B dollars and \$2.40 million federal matching dollars for enhanced Medi-Cal payments, to the five (5) Non-County Pediatric Trauma Hospitals are as follows:

Additional Funding to Support Pediatric Trauma Care

Cedars-Sinai Medical Center	\$ 393,980
Children’s Hospital Los Angeles	\$ 1,945,338
MemorialCare Long Beach Medical Center	\$ 1,492,722

Dignity Health-Northridge Hospital Medical Center	\$ 971,736
Ronald Reagan UCLA Medical Center	<u>\$ 598,112</u>
Total	\$ 5,401,888

On July 15, 2025, the Board of Supervisors approved an additional increase to the assessment rate of \$0.0130 per improved square foot, resulting in a total assessment rate of \$0.0630 per improved square foot. The additional revenue from the Measure B tax rate increase is projected to generate approximately \$86.60 million annually. Of this revenue, the Board approved granting \$14.94 million of the new annual ongoing revenue starting in FY 2025-26 to support participating non-County Trauma Hospitals, ongoing investment in additional staffing, technology and capital improvements to maintain and/or expand the regional trauma system.

3. The total payments of \$26.01 million, including \$14.94 million from Measure B dollars and \$11.07 million in federal matching dollars for enhanced Medi-Cal payments, to the thirteen (13) Non-County Trauma Hospitals are as follows:

Additional Funding to Support Trauma Care System

Antelope Valley Hospital	\$ 2,042,576
Dignity Health-California Hospital Medical Center	\$ 3,981,488
Cedars-Sinai Medical Center	\$ 1,947,236
Children's Hospital Los Angeles	\$ 647,626
Henry Mayo Newhall Hospital	\$ 1,114,088
Huntington Hospital	\$ 1,566,532
MemorialCare Long Beach Medical Center	\$ 1,851,556
Dignity Health-Northridge Hospital Medical Center	\$ 2,355,736
Pomona Valley Hospital Medical Center	\$ 2,179,960
Providence Holy Cross Medical Center	\$ 2,466,302
Ronald Reagan UCLA Medical Center	\$ 1,835,910
St. Francis Medical Center	\$ 2,350,294

Dignity Health-St. Mary Medical Center	\$ 1,666,210
Total	\$ 26,005,514

The above payment amounts totaling \$41.78 million for this Section V include Measure B funding and federal matching. Except for Antelope and UCLA, the County intends to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to Antelope and UCLA.

VI. PAYMENT LIMIT

Contractor acknowledges that the amounts payable under Attachment A (“the Trauma SPA”) are limited to the uncompensated costs of providing outpatient hospital services of all eligible private trauma hospitals in Los Angeles County and are also limited by the State’s upper payment limit, as established in 42 C.F.R. Section 447.321. To the extent that either or both limits preclude the State from paying all the aggregate amounts set forth below, the amount to be recommended by the County for each private trauma hospital shall be reduced by the same percentage as the percentage of total allowable supplemental payments under the Trauma SPA is to total recommended supplemental Medi-Cal payments under the Trauma SPA to all private trauma hospitals.

VII. POTENTIAL IGT FOR FEDERAL MATCHING FUNDS

As discussed in Section III, the County intends that the Designation Support payments, Add-On Payments, a portion of the Patient-Based payments and any Additional Payments Due to Measure B Rate Increases, should they be allocated, to the private Non-County Trauma Hospitals be made as additional Medi-Cal payments in accordance with the Trauma SPA. Unless CDHCS rejects this payment approach, the County will transfer the non-federal share of such funds to CDHCS in one or more IGTs. The amount of the additional Medi-Cal payments to

the private Non-County Trauma Hospitals will be included in the amounts set forth in Sections I.A.1, III, IV and V above.

The parties acknowledge and agree that some or all of the IGT that the County intends to make to effectuate the provisions of this Agreement may not be qualify for a drawing down of federal matching funds under the Trauma SPA. To the extent that is true, the parties agree that the County shall have no obligation to make an IGT of such amounts and shall instead provide such IGT funds directly to the private Non-County Trauma Hospitals in proportion to the payments that would have been made to each hospital relating to such IGT funds if the funds had been accepted as a permissible IGT for which federal matching funds would be available under the Trauma SPA. To the extent that Non-County Trauma Hospitals receive the full amounts set forth in Section VIII below, County has no obligation to make further direct payments, even if not all of the funds set aside for use as an IGT are ultimately used for that purpose.

The total amount of the IGT the County intends to make shall be \$52.57 million.

VIII. TOTAL MAXIMUM PAYMENTS

The total maximum payments that each Non-County Trauma Hospital may receive, either directly from the County, or from the State of California, as additional Medi-Cal payments under the Trauma SPA (which includes the amounts of IGTs made by the County and federal matching funds), and subject to the limitations and conditions as described in this Agreement, shall be as follows:

Antelope Valley Hospital	\$ 9,421,518
Dignity Health-California Hospital Medical Center	\$ 18,364,884
Cedars-Sinai Medical Center	\$ 9,400,153
Children's Hospital Los Angeles	\$ 4,956,974
Henry Mayo Newhall Hospital	\$ 5,138,805
Huntington Hospital	\$ 7,225,731
MemorialCare Long Beach Medical Center	\$ 10,057,567

Dignity Health-Northridge Hospital Medical Center	\$ 12,437,731
Pomona Valley Hospital Medical Center	\$ 10,055,211
Providence Holy Cross Medical Center	\$ 11,375,985
Ronald Reagan UCLA Medical Center	\$ 9,090,790
St. Francis Medical Center	\$ 10,840,885
Dignity Health-St. Mary Medical Center	<u>\$ 7,685,504</u>
Total	\$126,051,738

Each non-County Trauma Hospital will be paid the above amounts through a combination of direct payments by the County or additional Medi-Cal payments under the Trauma SPA, except for UCLA and Antelope, which shall receive only funds from the County. Payments may be reduced to the extent that the amounts anticipated to be paid as Medi-Cal funds through the Trauma SPA cannot be paid in that manner, in which case the County will make direct payments of the non-federal share of such payments, up to, but not exceeding the amount of the IGT set forth above, less the amount used to fund the Medi-Cal payments which were actually made. Contractor shall promptly reimburse the County for any amounts received in excess of the above-stated maximums.

IX. EFFECTIVE DATES

The provisions of this Exhibit shall only apply to trauma services provided on or after July 1, 2025 and before July 1, 2026.

LOS ANGELES COUNTY TRAUMA DATABASE INCLUSION CRITERIA

TRAUMA CENTER SERVICE AGREEMENT PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM

EXCLUSIONS:

Patients with the following injuries are to be **EXCLUDED** from the registry, unless an additional injury that meets criteria/guidelines exists:

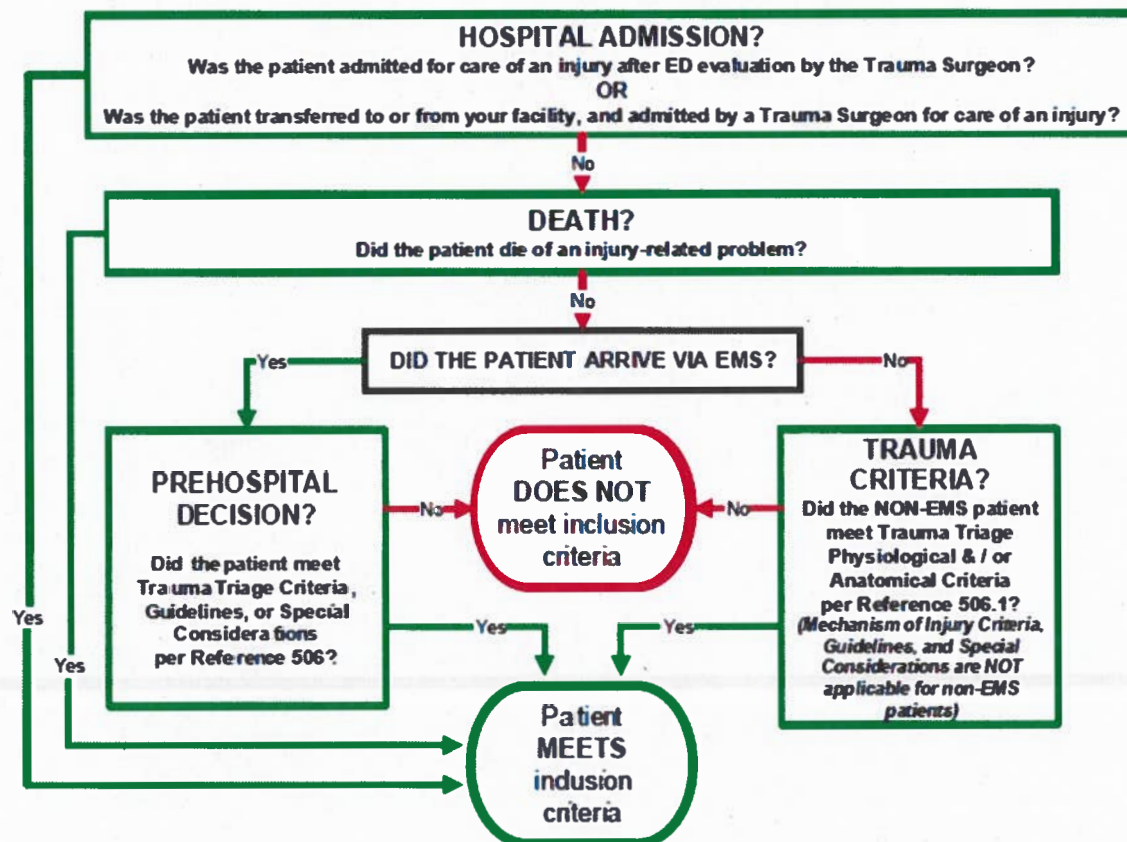
GROUND LEVEL FALLS:
resulting in isolated closed hip fractures in patients > 50 years of age; or
ALL injuries of or distal to the knee or elbow in patients of any age

OR

drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries (S00, S10, S20, S30, S40, S50, S60, S70, S80, & S90); insect bites; isolated injuries to fingers and/or toes; and injury codes that do not generate an ISS.

INCLUSIONS:

Does the patient have at least one ICD-10 injury diagnostic code within the range of S00 - S99; T20-T28; T30-T32; & T79.A1 - T79.A9?



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET THE INCLUSION CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

January 1, 2021 (Implemented)
Valid until amended by the EMS Agency
(Replaces Exhibit C dated January 1, 2020)



NOTICE

**MEDICAL CARE FOR THOSE WHO
CANNOT AFFORD TO PAY**

THIS HEALTH CARE FACILITY PROVIDES SERVICES FREE OF CHARGE OR AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OR BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (562) 378-1590.



NOTICIA

**SERVICIO MEDICO PARA QUIENES
NO PUEDEN AFRONTAR PAGARLO**

**ESTE HOSPITAL PROVEE SERVICIOS GRATIS O A COSTO REDUCIDO
A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.**

**SI USTED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE
NECESITA, USTED DEBE COMUNICARSE CON LA OFICINA DE
ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PREGUNTAR
ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION,
PUEDA LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL
COORDINADOR DEL SECTOR PRIVADO, AL (562) 378-1590.**

Trauma Service Hospital/Physician

Medical Record Number

Date(s) of Service

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

Last First Middle

Street City State Zip

Social Security Number Telephone Number Birth Date

Patient's Responsible Relative(s) Name(s) Addresses(s)

Does patient have third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES [] (IF YES, PATIENT IS NOT ELIGIBLE) NO []

TSCE ELIGIBILITY COMPUTATION: (Taken from 2026 Federal Poverty Level 4/1/26)

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Table with 3 columns: Family Size, Monthly Income, Yearly Income. Rows 1-12.

(For family units with more than 12 members, add \$948 monthly and \$11,360 yearly for each additional member.)

My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD OR FIRST PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

Patient's Signature

Date

Responsible Relative(s) Signature (State relationship to patient) If patient unable to sign

Date

TSCE Hospital Reviewer (Required to verify above information and signature)

Date

THIS FORM OR A HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE AGREEMENT FORM MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART

Instructions for Submission of Trauma Claims and Data Collection

- 6.1 Instructions for Submission of Trauma Claims and Data Collection
- 6.2 Instructions for Completion of the UB-04 Form
- 6.3 Instructions for Completion of the Trauma Service County Eligibility (TSCE)
- 6.4 Instructions for Completion of the Hospital Certification of Inability to Cooperate
- 6.5 Instructions for Submission of the Tobacco Tax Combo Print-Out
- 6.6 Excel Electronic File of the UB-04 Inpatient Data Template
- 6.7 Excel Electronic File of the UB-04 Outpatient Data Template
- 6.8 Instructions for Completion of the Trauma Center Payment Surrender Form

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR SUBMISSION OF TRAUMA CLAIMS AND DATA COLLECTION

GENERAL INFORMATION

Hospitals must submit a **UB-04 Form**, a copy of the **Trauma Service County Eligibility (TSCE)**, or a copy of the **Hospital Certification of Inability to Cooperate** and a copy of the **Tobacco Tax Combo Print-out** for each eligible patient's care if they want an indigent patient claim to be considered in the formula for Trauma Center funds. Additionally, Hospitals must submit an **Excel Electronic File of the UB 04 Data** with the paper copy of the claim packet. If Hospital is unable to submit an electronic file of the UB-04, they must submit the required UB-04 data in an Excel or CSV file and submit an electronic copy of this file when claims are submitted.

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all information as required on the TSCE form. If, after reasonable efforts are made, some data elements cannot be obtained for services provided as EMERGENCY DEPARTMENT, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients shall not be accepted without completion of all data elements unless a reasonable justification is provided, e.g., "comatose on arrival and expired with no family or identification"**. In these cases, a **Hospital Certification of Inability to Cooperate** should be submitted.

In addition to the above claims submission requirements, if a refund is received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to the County, this must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment it received within sixty (60) days of receipt of such payment and must complete and submit a **TRAUMA CENTER PAYMENT SURRENDER FORM** with each surrendered payment.

HOSPITALS—SUBMIT CLAIMS TO:

Department of Health Services
Emergency Medical Services (EMS) Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670
Attention: HOSPITAL CLAIMS
Contact: Hospital Reimbursement Coordinator – (562) 378-1590

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE UB-04 FORM

The following fields on the UB -04 must be completed:

- 1 HOSPITAL
Hospital name and address
- 3a PATIENT CONTROL NUMBER
Unique patient identification number assigned by provider to retrieve individual accounts
- 3b. MEDICAL RECORD NUMBER
Patient's Medical Record Number
- 4 TYPE OF BILL
0111 for Inpatient claims or 0131 for Outpatient claims
- 6 STATEMENT COVERS PERIOD
FROM = **Admit date** THROUGH = **Discharge date**
- 8b PATIENT NAME
Patient's last, first name and middle initial
- 9a-d. PATIENT'S ADDRESS
Patient's full address
- 10 BIRTH DATE
Patient's date of birth
- 11 SEX
Patient's gender
- 42 REVENUE CODE
The appropriate numeric code to identify specific accommodations and/or ancillary services in ascending numeric order, by date of service if appropriate (i.e. **209 ICU**).
- 44 HCPCS CODE OR CPT CODE
The CPT-4 code set (Current Procedural Terminology, 4th Edition Fill from the left-most position (i.e. **99291**))
- 46 SERVICE Units
Length of Stay

INSTRUCTIONS FOR COMPLETION OF THE UB-04 FORM

- 47 TOTAL
Total charges
56. NATIONAL PROVIDER IDENTIFIER
The hospital's unique ten-digit NPI identification number
- 57 FACILITY ID NUMBER
The hospital's unique six-digit OSHPD number
- 60 INSURED'S UNIQUE IDENTIFIER
The Trauma Patient Sequence (TPS) number
- 67 PRINCIPAL DIAGNOSIS
The complete ICD-10 CM diagnosis code that describes the principal diagnosis or the chief reason for performing a service on an outpatient basis
- 67a-q OTHER Dx CODES
The complete ICD-10-CM diagnosis codes for up to 17 additional conditions, **if applicable**
74. PRINCIPAL PROCEDURE CODE AND DATE
The ICD code that identifies the principal procedure and the date of those procedures, **if applicable**
- 74 a-e OTHER PROCEDURES DESCRIPTIONS
Other ICD codes identifying all significant procedures performed. **if applicable**

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)**GENERAL INFORMATION**

Hospitals must submit a copy of the completed and signed **Trauma Service County Eligibility (TSCE)** for each eligible patient's care, if they are claiming reimbursement for Trauma Hospital funds.

The TSCE shall be utilized by Contractor as the sole means for determining each patient's eligibility for trauma care coverage during the term of this Agreement. The TSCE must be completed and signed by the patient or the patient's responsible relative(s).

NOTE: If a TSCE cannot be secured because the patient or the patient's responsible relative (s) is (are) unable to cooperate to that effect, a Hospital Certification of Inability to Cooperate must be completed.

Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all data elements on the following questions:

- 3rd party coverage question
- Family size/income
- Signature (by patient or responsible relative only)
- Obtain signature of Hospital Reviewer/Translator who obtained information and explained program to patient at the time it is determined that eligibility requirements have been met.

TRAUMA SERVICE HOSPITAL/PHYSICIAN

Enter Trauma Hospital where services were provided

MEDICAL RECORD NUMBER

Enter Medical Record Number

DATES OF SERVICE

Enter month, day, and year of service

PATIENT INFORMATION

Enter patient's last name

Enter first name

Enter middle initial

PATIENT'S ADDRESS

Enter patient's street address

Enter city

Enter state

Enter zip code

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)

SOCIAL SECURITY

Enter patient's social security number

TELEPHONE NUMBER

Enter patient's area code and telephone number

BIRTHDATE

Enter patient's date of birth

PATIENT'S RESPONSIBLE RELATIVE(S) NAME

Enter name of patient's Responsible Relative (s) (only If patient is unable to sign)

Enter full address of Responsible Relative(s)

Key Points: Responsible relative means any relative of the patient that can obtain all information needed to complete the TSCE Agreement, including information regarding the patient's income, family size, and the patient's third-party coverage (if any)

TPL QUESTION

Check appropriate box to indicate if patient has third party coverage.

Key Points: Ensure that the Yes or No box is checked.

CIRCLE ONE IN EACH COLUMN BELOW

FAMILY SIZE

Circle the number of individuals related by birth, marriage, or adoption who usually share the same place of residence.

MONTHLY INCOME

Circle the appropriate total of patient's or patient's family's primary wage earner's wages and salaries.

Key Points: Write in the patient's monthly income if the total is less than what is indicated on the form.

YEARLY INCOME

Circle the appropriate total of patient's or patient's family's primary wage earner yearly income.

Key Points: Write in the patient's yearly income if the total is less than what is indicated on the form.

CIRCLE ONE IN EACH COLUMN BELOW

For family units with more than 12 members, add \$918 monthly and \$11,000 yearly for each additional member.)

PATIENT'S SIGNATURE AND DATE

Signature of patient

Enter date

Key Points: Ensure that patient completes, signs and dates the form at the time it is determined that eligibility requirements have been met.

Note: The patient's Responsible Relative should not sign in this section

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)

RESPONSIBLE RELATIVE SIGNATURE AND DATE

Responsible Relative(s) Signature (only if patient is unable to sign)

Enter the relationship to patient

Enter date

Key Points: Ensure that the patient's Responsible Relative completes, signs and dates the form at the time it is determined that eligibility requirements have been met. Include the relationship of the Responsible Relative to the patient.

TSCE HOSPITAL REVIEWER SIGNATURE AND DATE

Hospital Reviewer's Signature

Signature of translator who obtained information and explained program to patient)

Enter date

Key Points: Ensure that the Hospital Reviewer signs and dates the form at the time it is determined that eligibility requirements have been met. This form or a Hospital Certification of Inability to Cooperate must be on file in the patient's financial chart.

Trauma Service Hospital/Physician

Medical Record Number

_____/_____/_____
Date(s) of Service

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

Last First Middle

Street City State Zip

_____-_____-_____
Social Security Number () Telephone Number ____/____/_____
Birth Date

Patient's Responsible Relative(s) Name(s) Address(es)

Does patient have third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES (IF YES, PATIENT IS NOT ELIGIBLE) NO

TSCE ELIGIBILITY COMPUTATION: (Taken from 2025 Federal Poverty Level 4/1/25)

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Family Size	Monthly Income	Yearly Income
1	\$2,610	\$31,300
2	3,526	42,300
3	4,442	53,300
4	5,360	64,300
5	6,276	75,300
6	7,192	86,300
7	8,110	97,300
8	9,026	108,300
9	9,942	119,300
10	10,860	130,300
11	11,776	141,300
12	\$12,692	\$152,300

(For family units with more than 12 members, add \$918 monthly and \$11,000 yearly for each additional member.)

My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD-PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD-OR FIRST-PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

Patient's Signature

_____/_____/_____
Date

Responsible Relative(s) Signature (State relationship to patient)
If patient unable to sign

_____/_____/_____
Date

TSCE Hospital Reviewer (Required to verify above information and signature)

_____/_____/_____
Date

**THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART
Trauma Center Provisions for Reimbursement MOA-Exhibit A**

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

GENERAL INFORMATION

If a Trauma Service County Eligibility (TSCE) cannot be secured because the patient or the patient's responsible relative (s) (are) unable to cooperate to that effect, hospital must submit a copy of the completed and signed Attachment '**Hospital Certification of Inability to Cooperate**' for each eligible patient's care if they are claiming reimbursement for Trauma Hospital funds.

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for this program.

Do not use this form because TSCE form was mailed out and not completed nor returned by patient.

This form or a Trauma Service County Eligibility (TSCE) must be on file in the patient's financial chart.

1. TRAUMA SERVICE HOSPITAL/PHYSICIAN
Enter Trauma Hospital where services were provided
2. MEDICAL RECORD NUMBER
Enter Patient's Medical Record Number
3. DATE OF SERVICE
Enter month, day, and year of service
- 4-6. PATIENT INFORMATION
Enter patient's last name
Enter first name
Enter middle initial
- 7-10. PATIENT'S ADDRESS
Enter patient's street address
Enter city
Enter state
Enter zip code
- 11-12. PATIENT'S RESPONSIBLE RELATIVE(S) NAME
Enter name of patient's Responsible Relative (s) (only If patient is unable to sign)
Enter full address of patient's Responsible Relative(s)
13. SOCIAL SECURITY NUMBER
Enter patient's Social Security Number
14. TELEPHONE NUMBER
Enter patient's area code with telephone number

INSTRUCTIONS FOR COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

15. BIRTHDATE
Enter patient's birth date

16. REASON PATIENT UNABLE TO SIGN
Explain why the patient was unable to sign
Key Points: Indicate the patient's medical condition

Note: If patient walks out of the facility, refuses, or is unwilling to sign the form, this claim will not be eligible for payment

17. HOSPITAL REVIEWER #1
Signature of Hospital Reviewer/Translator who obtained information

18. DATE
Signature and date should be at the time of patient registration
Key Points: Ensure that the Hospital Reviewer signs and dates the form at the time it is determined that eligibility requirements have been met.

19. HOSPITAL REVIEWER #2
Signature of Hospital Reviewer's Supervisor and date

20. DATE
Date supervisor signed

This form or a Trauma Service County Eligibility (TSCE) must be on file in the patient's financial chart.

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE_____
Trauma Service Hospital/Physician_____
Medical Record Number_____
Date(s) of Service**NOTE:** Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.**PATIENT INFORMATION:**_____
Last First Middle_____
Street City State Zip_____
Patient's Responsible Relative(s) Name(s) Address(es)_____
Social Security Number () Telephone Number Birth date

WE CERTIFY UNDER PENALTY OF PERJURY BY OUR SIGNATURES THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

- 1) Obtain the names and addresses of the patient and the patient's responsible relatives,
- 2) Obtain acceptable address verification, and
- 3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third-party coverage.

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because:

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD- PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WE WERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

Hospital Reviewer #1_____
Date_____
Hospital Reviewer #2_____
Date

THIS FORM MUST BE SIGNED BY TWO HOSPITAL STAFF VERIFYING THE REASON THE PATIENT AND/OR THE PATIENT'S RESPONSIBLE RELATIVES, IF ANY, WERE UNABLE TO COOPERATE AND SHOULD BE COMPLETED AT THE TIME OF REGISTRATION AND FINANCIAL INFORMATION IS COLLECTED FOR THIS ACCOUNT.

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART
Trauma Center Provisions for Reimbursement MOA-Exhibit A

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR SUBMISSION OF THE TOBACCO TAX COMBO PRINT-OUT

GENERAL INFORMATION

The **Tobacco Tax Combo print-out** submitted with the claim is used to verify that the required trauma center's data is in the Trauma Emergency Medical Indigent Service (TEMIS) database. Hospitals must ensure that all like data elements in the TEMIS database match the UB-04 data for trauma patients.

The Tobacco Tax Combo print-out information from the EMS Agency's database, the print-out submitted from the hospital and data from the UB-04 must match. Only patients identified in TEMIS as "County Indigent" will be considered eligible for inclusion in the County's payment methodology to Trauma Centers.

VALIDATION OF TOBACCO TAX COMBO PRINT-OUT

<u>Data to Be Validated</u>	<u>Line # on Print-out</u>	<u>Box # on UB 04</u>	<u>Validation Requirement</u>
DHS Patient?	2	N/A	Must indicate DHS Y
Name	6	8b	Patient's last and first name must be correctly spelled
Adm Date	23	6 from	Admit date must match
D/C Date	24	6 through	Discharge date must match
Service Setting	28	4	ED or Ward
Payor 1	31	N/A	Must indicate County Indigent
Charges	33	47	Total Charges must match
Medical Record #	38	3b	Medical Record # must match
Date of Birth	39	10	DOB must match

LA County DHS TOBACCO TAX COMBO PRINT-OUT

Trauma Center	HCH	
DHS Patient?	Y	←Line #2
Acct #	123456789	
TPS #	C12345678912	
SS#	123-45-6789	
Name	DOE, JOHN	←Line #6
Parent Last	*BL	
Parent First	*BL	
Birth City	COLUMBIA	
Birth State	South Carolina	
Birth Country	UNITED STATES	
Mdn Name	BARKER	
Race	White	
Empl Typ	Unemployed	
Mo Inc	1,500	
Fam#	4	
Source	Wages	
Date Arr in ED	10/28/2020	
Time Arr in ED	00:49	
Date out ED	10/28/2020	
Time out ED	05:26	
ED TO:	WARD	
Adm date	10/28/2020	←Line #23
D/C Date	10/30/2020	←Line #24
DC Time	14:54	
Hosp D/C TO	*N/A	
D/C To	HOME W/O	
D/C From	WARD	←Line #28
LOS	3	
L/D	L	
Payor 1	COUNTY INDIGENT	←Line #31
Payor 2	*BL	
Charges	113030.52	←Line #33
St#	1313	
Street	MOCKING BIRD LANE	
City	ANY TOWN	
ZIP	99999	
MR#	12345678	←Line #38
DOB	3/16/1990	←Line #39
Age	30 Y	
ICD-10 1	S35.8X1A	
ICD-10 2	S36.539A	
ICD-10 3	S36.439A	
ICD-10 4	S31.611A	
Procedure 1	06HN33Z	
Procedure 2	30233N1	

HOSPITAL'S TOBACCO TAX COMBO PRINT-OUT

Trauma Center	HCH
DHS Patient?	Y ←Line #2
Acct #	123456789
TPS #	CI12345678912
SS#	123-45-6789
Name	DOE, JOHN← ←Line #6
Parent Last	*BL
Parent First	*BL
Birth City	COLUMBIA
Birth State	South Carolina
Birth Country	UNITED STATES
Mdn Name	BARKER
Race	White
Empl Typ	Unemployed
Mo Inc	1,500
Fam#	4
Source	Wages
Date Arr in ED	10/28/2020
Time Arr in ED	00:49
Date out ED	10/28/2020
Time out ED	05:26
ED TO:	WARD
Adm date	10/28/2020 ←Line #23
D/C Date	10/30/2020 ←Line #24
DC Time	14:54
Hosp D/C TO	*N/A
D/C To	HOME W/O
D/C From	WARD ←Line #28
LOS	3
L/D	L
Payor 1	COUNTY INDIGENT ←Line #31
Payor 2	*BL
Charges	113030.52 ←Line #33
St#	1313
Street	MOCKING BIRD LANE
City	ANY TOWN
ZIP	99999
MR#	12345678 ←Line #38
DOB	3/16/1990 ←Line #39
Age	30 Y
ICD-10 1	S35.8X1A
ICD-10 2	S36.539A
ICD-10 3	S36.439A
ICD-10 4	S31.611A
Procedure 1	06HN33Z
Procedure 2	30233N1

**EXCEL ELECTRONIC FILE OF THE UB-04
INPATIENT DATA TEMPLATE**

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04
INPATIENT DATA

GENERAL INFORMATION

Hospitals must submit an **Excel Electronic File of the UB-04 data** with the paper copy of the trauma claim packet to the EMS Agency. Data is to be captured from the UB-04 data fields as indicated below:

(**Inpatient Template** listing order)

Column letter and number	UB Field No.	FIELD NAME	INSTRUCTIONS FOR INPATIENT TEMPLATE
A-C	N/A	Clm#/Hosp Code/FY	•Leave blank- EMS will complete
D	8b	LAST NAME	•Enter patient's last name
E	8b	FIRST NAME	•Enter patient's first name
F	60	Seq#	•Enter the TPS # Insured's unique ID
G	N/A	(LOS) Length of Stay	•Leave blank - EMS will complete
H	4	Type of bill	•Enter IP for 111=Inpatient
I	6	Admission Date	•Enter the from (admit date)
J	6	Discharge Date	•Enter the through (discharge date)
K	47	TOTAL CHARGES	•Enter Total Charges
L-1	N/A	GPP Service Category, Tier, and Type	• Leave Blank
M-2	57	Facility ID number	•Leave blank- EMS will complete
N-3	56	National Provider Identifier	•Leave blank- EMS will complete
O-4	3a Pat Cnt#	Unique patient ID	•Enter patient's unique number assigned by provider
P-5	6	Admission Date	Enter admit date as yyyyymmdd
Q-6	6	Discharge Date	Enter discharge date as yyyyymmdd
R-7	N/A	# of GPP Days	•Leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column letter and number	UB Field No	FIELD NAME	INPATIENT TEMPLATE INSTRUCTIONS
S-8	42	REVENUE CODE	•Enter the appropriate numeric code to identify specific accommodations and/or ancillary service in ascending numeric order, by date of service if appropriate. For example: •209 (ICU)
T-9	67	PRINCIPAL DIAGNOSIS	•Enter the complete ICD-10-CM diagnosis code that describes the principal diagnosis or the chief reason for performing a service on an outpatient basis.
U-10 AR-33	67a- 67x	OTHER DX CODES	•Enter the complete ICD-10-CM diagnosis codes for up to 17 additional conditions If applicable
AS-34	74	Principal Procedure Code	•Enter the ICD code that identifies the principal procedure
AT-35 AX-39	74a- e	Other procedure Code/Date	•Enter other ICD codes identifying all significant procedures performed. •Enter the date of those procedures. If applicable
AY-40 BQ-58	74f-x	Other procedure 6-24	•Leave blank
BR-59	10	BIRTHDATE	•Enter patient's date of birth yyyyymmdd
BS-60	11	Gender Identity	•Leave blank-EMS will complete
BT-61	9D	ZIP CODE	•Enter patient's Zip Code
BU-62	N/A	Race	•Leave blank-EMS will complete
BV-63	N/A	Race 1	•Leave blank-EMS will complete
BW-64	N/A	Race 2	•Leave blank-EMS will complete
BX-65	N/A	Ethnicity	•Leave blank-EMS will complete
BY-66	N/A	Preferred Language Spoken	•Leave blank
BZ-67	N/A	Sexual Orientation	•Leave blank-
CA-68	N/A	Length of Stay	•Leave blank-EMS will complete
CB-69	N/A	Jimmy's Comments	•Leave blank-EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column						
A	B	C	D	E	F	G
Clm #	Hosp Code	FY	Last Name	First Name	Seq #	LOS
BOX # ON UB	1		8b	8b	60	45
EMS will complete	EMS will complete	EMS will complete	DOE	JOHN	C12345678901	EMS will complete

Column				
H	I	J	K	L
IP	Admission Date	Discharge Date	Total Charges	GPP Service Category, Tier, and Type
				(1)
				Four-digit code to distinguish each GPP service type. First digit represents service category, second digit represents tier, and last two digits represent service type
4	6	6	47	N/A
IP	07/27/2018	08/02/2018	\$ 157,689.60	leave blank

**INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04
INPATIENT DATA**

Column
M

Facility ID number	National Provider Identifier
(2)	(3)
Can be OSHPD's 6-digit ID number (hospital), or other facility ID number (state provider code, tax ID, etc). If no facility ID or using NPI to identify facility, then 000000	NPI Identification Number; 0000000000 if unknown
57	56
EMS will Complete	EMS will Complete

N

Column
O

Unique patient ID	Admission Date	Discharge Date	# of GPP days
(4)	(5)	(6)	(7)
Unique patient identification number (May not be unique across organization)	Single-digit months and days must include a preceding zero. yyyymmdd.	Single-digit months and days must include a preceding zero. yyyymmdd.	Normally Discharge date - Admission date. However, limited scope will have a lower number of days.
3a	6	6	N/A
123456789	20180727	20180802	leave blank

P

Q

R

Column
S

Revenue Code	Principal diagnosis	Other diagnosis 1	Other diagnosis 2	Other diagnosis 3
(8)	(9)	(10)	(11)	(12)
Revenue Code used on UB04 (I/P ward)	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
42	67	67a	67b	67c
0200	S02651B	J9600	R402112	R402222

T

U

V

W

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column				
X	Y	Z	AA	AB
Other diagnosis 4	Other diagnosis 5	Other diagnosis 6	Other diagnosis 7	Other diagnosis 8
(13)	(14)	(15)	(16)	(17)
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67d	67e	67f	67g	67h
R402342	S0232XB	S022XXA	H1132	S02652B

Column				
AC	AD	AE	AF	AG
Other diagnosis 9	Other diagnosis 10	Other diagnosis 11	Other diagnosis 12	Other diagnosis 13
(18)	(19)	(20)	(21)	(22)
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67i	67j	67k	67l	67m
S0240FA	N200	S199XXA	R55	T401X4A

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column

AH	AI	AJ	AK	AL
Other diagnosis 14	Other diagnosis 15	Other diagnosis 16	Other diagnosis 17	Other diagnosis 18
(23)	(24)	(25)	(26)	(27)
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67n	67o	67p	67q	67r
Z23	T401X4A	Z24	T401X4A	Z25

Column

AM	AN	AO	AP	AQ
Other diagnosis 19	Other diagnosis 20	Other diagnosis 21	Other diagnosis 22	Other diagnosis 23
(28)	(29)	(30)	(31)	(32)
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67s	67t	67u	67v	67w
T401X4A	Z26	T401X4A	Z27	T401X4A

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column AR	AS	AT	AU	AV
Other diagnosis 24	Principal procedure	Other Procedure 1	Other Procedure 2	Other Procedure 3
(33)	(34)	(35)	(36)	(37)
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)
67x	74	74a	74b	74c
Z28	0NSN04Z	0NSTXZZ	0NSVXZZ	5A1935Z

Column AW	AX	AY	BQ
Other Procedure 4	Other Procedure 5	Other Procedure 6	Other Procedure 24
(38)	(39)	(40)	(58)
ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)
74d	74e	74f	74x
0BH17EZ	2W31X9Z	Leave blank	Leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column BR	BS	BT
Date of Birth	Gender Identity	Zipcode
(59)	(60)	(61)
Single-digit months and days must include a preceding zero. yyyymmdd.	446151000124109 - Male 446141000124107 - Female 407377005 - Female-to-Male (FTM)/ Transgender Male/Trans Man 407376001 - Male-to-Female (MTF)/ Transgender Female/Trans Woman 446131000124102 - Genderqueer, Non-binary, neither exclusively male nor female OTH - Additional gender category or other, please specify ASKU - Choose not to disclose	XXXXX = unknown; yyyyy = foreign; zzzzz = homeless;
10	Not on UB	9d
19720821	EMS will complete	Enter Zip Code

Column BU	BV	BW
Race	Race 1	Race 2
(62)	(63)	(64)
Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer
Not on UB	Not on UB	Not on UB
EMS will complete	EMS will complete	EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column BX	BY
Ethnicity	Preferred Language Spoken
(65)	(66)
1 – Hispanic or Latino 2 – Non-Hispanic or Non-Latino 3 – Unknown 4 – Declined to Answer	In alignment with the Department of Health Care Access and Information (HCAI) reporting, systems must report using one of the following options: <ul style="list-style-type: none"> • 3-character PLS codes listed in CA Title 22 Regulations (section 97234); OR • 3-character PLS codes from the ISO 639-2 Code List; OR <ul style="list-style-type: none"> • If the preferred language spoken is not one of the codes listed, enter the full name of the language, up to 24 characters • Report 999 for Unknown
Not on UB	Not on UB
EMS will complete	leave blank

Column BZ	CA	CB
Sexual Orientation	LOS	Jimmy's Comments
(67)	(68)	(69)
38628009 - Lesbian, gay or homosexual 20430005 - Straight or heterosexual 42035005 - Bisexual OTH - Something else UNK - Don't know ASKU - Choose not to disclose		<ul style="list-style-type: none"> - If column CA is not equal to "0", please explain below the reason your LOS is different from the formula. - If the patient has a fictitious name such as "Trauma" or "John Doe" or "Jane Doe", please validate and comment below. - If the patient has DOB is unknown, please validate and comment below. - Please explain anything below that you consider is important to be noted.
Not on UB	LOS	Not on UB
leave blank	EMS will complete	EMS will complete

**EXCEL ELECTRONIC FILE OF THE UB-04
OUTPATIENT DATA TEMPLATE**

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

GENERAL INFORMATION

Hospitals must submit an **Excel Electronic File of the UB-04 data** with the paper copy of the trauma claim packet to the EMS Agency. Data is to be captured from the UB-04 data fields as indicated below:

(**Outpatient Template** listing order)

Column Letter and Number	UB Field No.	FIELD NAME	INSTRUCTIONS FOR OUTPATIENT TEMPLATE
A-C	N/A	Clm #/Hosp Code/FY	•Leave blank- EMS will complete
D	8b	Last Name	•Enter patient's last name
E	8b	First Name	•Enter patient's first name
F	60	Insured's unique ID	•Enter the Sequence (TPS) #
G	4	VISIT	•Enter 1 for Outpatient claims
H	4	ED	•Enter ED for Code 131=Outpatient
I	6	Admission Date	•Enter date Statement Covers Period From
J	6	Discharge Date	•Enter date Statement Covers Period Through
K	47	TOTAL CHARGES	•Enter Total Charges
L-1	N/A	GPP Service Category, Tier, and Type	•Leave blank
M-2	57	Facility ID number	•Leave blank- EMS will complete
N-3	56	National Provider Identifier	•Leave blank- EMS will complete
O-4	3a Pat Cntl#	Unique patient ID	•Enter patient's unique number assigned by provider
P-5	6	Service Date	•Enter the from (admit date) as yyyyymmdd
Q-6	N/A	# of GPP Units	•Leave blank

**INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04
OUTPATIENT DATA**

Column Letter and Number	UB Field No.	FIELD NAME	INSTRUCTIONS FOR OUTPATIENT TEMPLATE
R-7	67	PRINCIPAL DIAGNOSIS	•Enter the complete ICD-10-CM diagnosis code that describes the principal diagnosis or the chief reason for performing a service on an outpatient basis.
S-8 - AP-31	67A-67X	OTHER DX CODES	•Enter the complete ICD-10-CM diagnosis codes for up to 17 additional conditions If applicable
AQ-32	74 or 44 (CPT code)	Principal procedure	•CPT-4 code set (Current Procedural Terminology, 4th Edition); Fill from the left-most position IE (99291)
AR-33 - CN-81	N/A	Principal Procedure Code modifier	•Leave blank
CO-82	10	Date of Birth	•Enter yyyymmdd
CP-83	11	Gender Identity	•Leave blank- EMS will complete
CQ-84	9D	ZIP CODE	•Enter patient's Zip Code
CR-85	N/A	Race	•Leave blank- EMS will complete
CS-86	N/A	Race 1	•Leave blank
CT-87	N/A	Race 2	•Leave blank
CU-88	N/A	Ethnicity	•Leave blank- EMS will complete
CV-89	N/A	Preferred Language	•Leave blank
CW-90	N/A	Sexual Orientation	•Leave blank-
CX-91	N/A	Length of stay	•Leave blank- EMS will complete
CY-92	N/A	Jimmy's Comments	•Leave blank- EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

A B C D E F G H

Clm #	Hosp Code	FY	Last Name	First Name	Seq #	Visit	ED
BOX # ON UB	1		8b	8b	60	6	4
EMS will complete	EMS will complete	EMS will complete	DOE	JOHN	CI234567890	1	ED

Column

I J K L

Admission Date	Discharge Date	Total Charges	GPP Service Category, Tier, and Type
			1
			Four-digit code to distinguish each GPP service type. First digit represents service category, second digit represents tier, and last two digits represent service type (see column A of "service cat_tier_type codes" tab)
6	6	47	N/A
12/31/2018	12/31/2018	\$26,209.60	leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

M

N

Facility ID number	National Provider Identifier
2	3
OSHPD's 6-digit ID number (hospital), or other facility ID number (state provider code, tax ID, etc). If no facility ID or using NPI to identify facility, then 000000	NPI Identification Number; 0000000000 if unknown
57	56
EMS will complete	EMS will complete

Column

O

P

Unique patient ID	Service Date
4	5
Unique patient identification number (May not be unique across organization)	Single-digit months and days must include a preceding zero. The transmittal process will populate the database field by moving the first 4 digits to the end of the field. EXAMPLE: Field in File equals 20040301. Database value will contain 03012004. The database value represents the date format mmdccyy.
3a	6 Admit date only
1213456789	20181231

Column

Q

R

S

T

U

V

# of GPP days	Principal diagnosis	Other diagnosis 1	Other diagnosis 2	Other diagnosis 3	Other diagnosis 4
6	7	8	9	10	11
Number of GPP services provided	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
N/A	67	67A	67B	67C	67D
leave blank	S01412A	S41012A	S41011A	S41111A	S51821A

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

W

X

Y

Z

AA

AB

Other diagnosis 5	Other diagnosis 6	Other diagnosis 7	Other diagnosis 8	Other diagnosis 9	Other diagnosis 10
12	13	14	15	16	17
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67E	67F	67G	67H	67I	67J
S810012A	S51821A	S810012A	S51821A	S810012A	S51821A

Column

AC

AD

AE

AF

AG

AH

Other diagnosis 11	Other diagnosis 12	Other diagnosis 13	Other diagnosis 14	Other diagnosis 15	Other diagnosis 16
18	19	20	21	22	23
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67K	67L	67M	67N	67O	67P
S810012A	S51821A	S810012A	S51821A	S810012A	S51821A

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

AI	AJ	AK	AL	AM	AN
Other diagnosis 17	Other diagnosis 18	Other diagnosis 19	Other diagnosis 20	Other diagnosis 21	Other diagnosis 22
24	25	26	27	28	29
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67Q	67R	67S	67T	67U	67V
S810012A	leave blank	leave blank	leave blank	leave blank	leave blank

Column

AO	AP	AQ	AR through	CN
Other diagnosis 23	Other diagnosis 24	Principal procedure	Principal Procedure Code modifier	Other Procedure code 24 modifier
30	31	32	33	81
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	CPT-4 code set (Current Procedural Terminology, 4th Edition); Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces	CPT and HCPCS Modifiers associated with the specified GPP service codes. (Refer to the specific GPP services description for the allowable codes). If multiple modifiers are reported for the same principal procedure code, use comma delimited	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces
67W	67X	74 or 44 (CPT code)	74A	74Y
leave blank	leave blank	99291	leave blank	leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column
CO

CP

CQ

Date of Birth	Gender Identity	Zip code
82	83	84
Single-digit months and days must include a preceding zero. yyyymmdd.	446151000124109 - Male 446141000124107 - Female 407377005 - Female-to-Male (FTM)/ Transgender Male/Trans Man 407376001 - Male-to-Female (MTF)/ Transgender Female/Trans Woman 446131000124102 - Genderqueer, Non-binary, neither exclusively male nor female OTH - Additional gender category or other, please specify ASKU - Choose not to disclose	XXXXX = unknown; yyyyy = foreign; zzzzz = homeless;
10	11	9D
19841001	EMS will complete	Enter Zip Code

Column
CR

CS

CT

Race	Race 1	Race 2
85	86	87
Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer
Not on UB	Not on UB	Not on UB
EMS will complete	Leave blank	Leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column
CU

CV

Ethnicity	Preferred Language
88	89
1 – Hispanic or Latino 2 – Non-Hispanic or Non-Latino 3 – Unknown 4 – Declined to Answer	In alignment with the Department of Health Care Access and Information (HCAI) reporting, systems must report using one of the following options: <ul style="list-style-type: none"> • 3-character PLS codes listed in CA Title 22 Regulations (section 97234); OR • 3-character PLS codes from the ISO 639-2 Code List; OR • If the preferred language spoken is not one of the codes listed, enter the full name of the language, up to 24 characters • Report 999 for Unknown
Not on UB	Not on UB
EMS will complete	Leave blank

Column
CW

CX

Sexual Orientation	LOS Length of stay
90	91
38628009 - Lesbian, gay or homosexual 20430005 - Straight or heterosexual 42035005 - Bisexual OTH - Something else UNK - Don't know ASKU - Choose not to disclose	
Not on UB	Not on UB
Leave blank	EMS will complete

Column

CY

Jimmy's Comments
92
<ul style="list-style-type: none"> - If column CX is not equal to "0", please explain below the reason your LOS is different from the formula. - If the patient has a fictitious name such as "Trauma" or "John Doe" or "Jane Doe", please validate and comment below. <ul style="list-style-type: none"> - If the patient has DOB is unknown, please validate and comment below. - Please explain anything below that you consider is important to be noted.
Not on UB
EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA PAYMENT SURRENDER FORM

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM**GENERAL INFORMATION**

Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment it received within sixty (60) days of receipt of such payment and must complete and submit a TRAUMA CENTER PAYMENT SURRENDER FORM with each surrendered payment.

COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

1. FACILITY
Enter the Trauma Center refunding the claim
2. PATIENT NAME
Enter the patient's name of claim being refunded
3. DATE OF SERVICE
Enter the patient's date of service
4. TPS#
Enter the Trauma Patient Sequence Number
5. DATE CLAIM SUBMITTED TO EMS AGENCY
Enter the date that trauma claim was submitted to EMS
6. AMOUNT OF PAYMENT BEING SURRENDERED
Enter the amount being refunded to EMS:
7. PAYMENT RECEIVED FROM
Check appropriate box to Indicate whom provided the refund
 - INSURANCE (Health Plan/HMO)
 - MEDI-CAL
 - MEDICARE
 - PATIENT
 - THIRD PARTY TORTFEASORS
 - OTHER _____
(Specify)

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

8. DATE COVERAGE IDENTIFIED
Enter the date coverage identified
9. SUBMITTED BY
Enter the name of person submitting the refund
10. DATE
Enter the date of refund
11. ATTACH COPY OF TRAUMA CENTER SURRENDER FORM
This form must be attached to each payment surrender check
12. MAIL REFUND TO
Los Angeles County/Department of Health Services
Finance – Special Program Funds
1000 S. Fremont Avenue
Unit 8, Building A11, 2nd Floor
Alhambra, CA 91803

TRAUMA CENTER PAYMENT SURRENDER FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: ____/____/____ TPS#: _____

DATE CLAIM SUBMITTED TO EMS AGENCY: ____/____/____

AMOUNT OF PAYMENT BEING SURRENDERED: \$_____

PAYMENT RECEIVED FROM

DATE COVERAGE IDENTIFIED

INSURANCE (Health Plan/HMO) ____/____/____

MEDI-CAL ____/____/____

MEDICARE ____/____/____

PATIENT ____/____/____

THIRD PARTY TORTFEASORS ____/____/____

OTHER _____ ____/____/____
(Specify)

SUBMITTED BY:

____/____/____
DATE:

(THIS FORM MUST BE ATTACHED TO EACH PAYMENT SURRENDER CHECK)

Mail to Los Angeles County/Department of Health Services
Finance – Special Program Funds
1000 S. Fremont Avenue
Unit 8, Building A11, 2nd Floor
Alhambra, CA 91803

**BOARD LETTER/MEMO
CLUSTER FACT SHEET**

Board Letter

Board Memo

Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input type="checkbox"/> All <input type="checkbox"/> 1 st <input checked="" type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Mental Health	
SUBJECT	Approval to sole source contract extension for 24-hour Residential Treatment Program with Telecare Corporation for Adult Psychiatric Health Facility services at the Martin Luther King Jr. Behavioral Health Center.	
PROGRAM	NA	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain why:	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Not Applicable If unsure whether a matter is subject to the Levine Act, email your packet to EOLevineAct@bos.lacounty.gov to avoid delays in scheduling your Board Letter.	
DEADLINES/ TIME CONSTRAINTS	6/9/26	
COST & FUNDING	Total cost: \$7,457,680	Funding source: Psychiatric Health Facility Funding
	TERMS (if applicable): 7/1/26 – 6/30/27	
	Explanation:	
PURPOSE OF REQUEST	Extending this contract ensures that vulnerable clients do not experience a disruption in mental health services. Will allow DMH to continue addressing service gaps in SA 1 as it relates to 24-Hour Residential Treatment Program for Adult Psychiatric Health Facility services.	
BACKGROUND (include internal/external issues that may exist including any related motions)	The Psychiatric Health Facility (PHF) is a 24-Hour Residential Treatment sub-acute facility that provides an alternative to acute hospital care. The 24-hour inpatient services in PHF for clients with mental health disorders are designed to provide innovative and comprehensive acute care services in a more home-like environment for Medi-Cal and Non Medi-Cal clients as an alternative to hospital care. Clients will receive therapeutic services such as vocational, interpersonal, and independent living skills in order to become more self-sufficient and capable of increasing levels of independent functioning.	
EQUITY INDEX OR LENS WAS UTILIZED	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain how:	

SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state which one(s) and explain how: Strategic Plan Goal I Make Investments that Transform Lives), via Strategy 1.2- Enhance Our Delivery of Comprehensive Interventions. The development of a 16-bed Psychiatric Health Facility directly expands the district's capacity to provide intensive, client-centered mental health services. By offering a safe, structured environment for individuals experiencing acute psychiatric needs, the facility strengthens our continuum of care and ensures timely access to comprehensive interventions. This investment enhances stabilization, supports recovery, and improves long-term outcomes for clients, aligning with the district's commitment to transformative, holistic support systems.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Paul Arns, Ph.D., (213) 921-1818, parns@dmh.lacounty.gov Rachel Kleinberg, (213) 392-6668, rkleinberg@counsel.lacounty.gov

DRAFT



DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL TO EXTEND THE EXISTING CONTRACT WITH TELECARE CORPORATION ON A SOLE SOURCE BASIS FOR ADULT PSYCHIATRIC HEALTH FACILITY SERVICES AT THE MARTIN LUTHER KING JR. BEHAVIORAL HEALTH CENTER (2ND SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval to extend the existing contract with Telecare Corporation, on a sole source basis, for Adult Psychiatric Health Facility services at the Martin Luther King Jr. Behavioral Health Center.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or designee, to prepare, sign, and execute an amendment substantially similar to Attachment I, to the existing contract with Telecare Corporation on a sole source basis, for Adult Psychiatric Health Facility (PHF) services at the Martin Luther King Jr. (MLK Jr.) Behavioral Health Center (BHC). This extension will be effective July 1, 2026, through June 30, 2027. The Maximum Contract Amount (MCA) is \$7,457,680, fully funded by Federal Financial Participation (FFP), State General Fund (SGF), and 2011 Realignment revenues.
2. Delegate authority to the Director, or designee, to prepare, sign, and execute future amendments to the contract in Recommendation 1 to: 1) exercise a one year optional extension for Fiscal Year (FY) 2027-28; 2) negotiate/revise contract language; 3) add, delete, modify, negotiate, or replace the Statement of Work Provider/Site List, including Service Exhibits and Financial Provisions; 4) reflect federal, State, and County regulatory

and/or policy changes; 5) take contract actions related to provisions within the Financial Provisions (Exhibit A); and 6) revise the annual MCA, provided that the County's total payment will not exceed an increase of more than 25 percent of the applicable annual MCA, given that sufficient funds are available and prior review and approval as to form by County Counsel with written notice to the Board and Chief Executive Office (CEO) are provided.

3. Delegate authority to the Director, or designee, to make non-material modifications to the contract in Recommendation 1 through administrative amendments or change notices for the following and other similar reasons, as appropriate: change the Contractor's business name and/or headquarter address; change, revise, add, or delete the Contractor's provider site address(es), site number(s), and/or site name(s); make technical corrections; revise County and Contractor Administration Exhibits; and or shift funds between currently contracted funded programs, so long as such shift(s) will not cause an increase in the MCA.

4. Delegate authority to the Director, or designee, to terminate the contract described in Recommendation 1 in accordance with the contract's termination provisions, including Termination for Convenience. The Director, or designee, will provide written notification to your Board and CEO of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Telecare Corporation provides essential around the clock acute psychiatric care within a County-owned facility. Extending this contract ensures continuity of care so that vulnerable clients do not experience a disruption in mental health services.

Board approval of Recommendation 1 will allow the Department of Mental Health (DMH) to amend the existing contract with Telecare Corporation for FY 2026-27, on a sole source basis for the continuation of services.

Board approval of Recommendations 2 and 3 will allow DMH to amend the contract in Recommendation 1 in a timely manner as necessary for the continuous provision and expansion of mental health services without interruption for clients in need of these services.

Board approval of Recommendation 4 will allow DMH to terminate the contract in accordance with the contract's termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

These recommended actions are consistent with the County's Strategic Plan Goals, North Star 1, Make investments that Transform Lives, Specifically Focus Area A – Healthy Individuals & Families.

FISCAL IMPACT/FINANCING

The MCA for FY 2026-27 is \$7,457,680, fully funded by FFP, SGF and 2011 Realignment revenues. Appropriation is included in DMH's annual Budget.

There is no net County cost impact associated with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The PHF is a 24-Hour Residential Treatment sub-acute facility that provides an alternative to acute hospital care. The 24-hour inpatient services in PHF for clients with mental health disorders are designed to provide innovative and comprehensive acute care services in a more home-like environment for Medi-Cal and Non Medi-Cal clients as an alternative to hospital care. Clients receive therapeutic services such as vocational, interpersonal, and independent living skills in order to become more self-sufficient and capable of increasing levels of independent functioning.

This contract was the result of a competitive solicitation - Invitation for Bids (IFB) No. DMH100522B1 released on October 5, 2022, for PHF services at the BHC on the MLK Jr. Campus for two distinct pods, adolescents and adults, inviting all qualified legal entities to submit a bid. Telecare Corporation was the only entity to respond to the solicitation by the November 30, 2022, deadline and their proposal was vetted and met the solicitation requirements to provide adult PHF services at MLK Jr. BHC.

In accordance with Board Policy No. 5.100 (Sole Source Contracts and Amendments), on April 3, 2026 (Attachment II) DMH notified the Board of its intent to execute a sole source amendment to the 24-hour Residential Treatment Program contract with Telecare Corporation for adult PHF services in a facility with 16 adult beds at MLK Jr. BHC located at 12021 Wilmington Avenue, Los Angeles, CA 90059. DMH considers this request approved, as no objections were received from the Board offices. Attachment III is the required CEO approved Sole Source checklist.

On April 10, 2026, DMH requested exemption to Board Policy No. 5.120 (Authority to Approve Increase to Board-Approved Contract Amounts) (Attachment IV) for increases

The Honorable Board of Supervisors
June 9, 2026
Page 4

to the contract in Recommendations 1 over 10%, and in accordance with the Policy, DMH considers this request approved, as we did not hear otherwise.

The amendment (Attachment I) has been approved as to form by County Counsel.

As mandated by your Board, the performance of the contractor is evaluated by DMH on an annual basis to ensure compliance with all contract terms and performance standards.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board approval of the proposed actions will allow DMH to continue addressing service gaps in Service Area 6 as it relates to 24-Hour Residential Treatment Program for Adult Psychiatric Health Facility services.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:RH:KN:
SK:HB:atm

Attachments (3)

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

CONTRACT NO. MH570031

AMENDMENT NO. 6

THIS AMENDMENT is made and entered into this ___ day of ___, 2026, by and between the COUNTY OF LOS ANGELES (hereafter "County"), and Telecare Corporation (hereafter "Contractor").

WHEREAS reference is made to that certain document entitled "Department of Mental Health (DMH) 24-Hour Residential Treatment Contract", dated May 1, 2024, and further identified as County Contract No. MH570031, and all prior amendments (hereafter collectively "Contract"); and

WHEREAS, on June 9, 2026, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute amendments to the Contract to add, delete, revise language and make certain designated changes; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

WHEREAS, County and Contractor intend to amend the Contract only as described hereunder; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of the Contract.

NOW, THEREFORE, the County and Contractor agree as follows:

1. This amendment is hereby incorporated into the original Contract, and all its terms and conditions, including capitalized terms defined therein, shall be given full force and effect as if fully set forth herein.
2. This amendment is effective upon execution for Fiscal Year (FY) 2026-27.
3. The term of this Contract is extended for one-year, effective July 1, 2026 through June 30, 2027.
4. Paragraph 4.0 (TERM OF CONTRACT), Subparagraph 4.1.3, is added to the Contract as follows:

“4.1.3 Extension Period: The extension of this Contract will commence on July 1, 2026 and will continue in full force and effect through June 30, 2027.”
5. For FY 2026-27, the Maximum Contract Amount (MCA) is \$7,457,680.
6. Exhibit A (FINANCIAL PROVISIONS), Attachment A-1 (Contractor Claims Certification for Title XIX Short-Doyle Medi-Cal and Title XXI Medicaid Children’s Health Insurance Programs Reimbursements) is added to the Contract for FY 2026-27, attached hereto and incorporated herein by reference.
7. Exhibit A (FINANCIAL PROVISIONS), Paragraph C (REIMBURSEMENT IF CONTRACT IS AUTOMATICALLY RENEWED), shall be deleted in its entirety and replaced as follows:

C. REIMBURSEMENT IF CONTRACT IS AUTOMATICALLY/OPTIONALLY RENEWED:

- (1) Reimbursement For First Automatic Renewal Period: The MCA for the First Automatic Renewal Period of the Contract as described in

Paragraph 4 (TERM OF CONTRACT) of the DMH Contract shall not exceed SEVEN MILLION FOUR HUNDRED FIFTY-SEVEN THOUSAND SIX HUNDRED EIGHTY DOLLARS (\$7,457,680) and shall consist of Funded Programs as shown in Exhibit B, Financial Summary.

(2) Reimbursement For Second Automatic Renewal Period: The MCA for the Second Automatic Renewal Period of the Contract as described in Paragraph 4 (TERM OF CONTRACT) of the DMH Contract shall not exceed SEVEN MILLION FOUR HUNDRED FIFTY-SEVEN THOUSAND SIX HUNDRED EIGHTY DOLLARS (\$7,457,680) and shall consist of Funded Programs as shown in Exhibit B, Financial Summary.

(3) Reimbursement For First Optional Renewal Period: The MCA for the First Optional Renewal Period of the Contract as described in Paragraph 4 (TERM OF CONTRACT) of the DMH Contract shall not exceed SEVEN MILLION FOUR HUNDRED FIFTY-SEVEN THOUSAND SIX HUNDRED EIGHTY DOLLARS (\$7,457,680) and shall consist of Funded Programs as shown in Exhibit B, Financial Summary.

8. Exhibit A (FINANCIAL PROVISIONS), Paragraph M (CASH FLOW ADVANCE (CFA) IN EXPECTATION OF SERVICES/ACTIVITIES TO BE RENDERED), subparagraph (8) (a), shall be deleted in its entirety and replaced as follows:

“(a) For each of the first two months of each period that the Contract is in effect, Contractor may request in writing from County a monthly County General Fund CFA for any funds which may be part of the MCA for such period as identified in the Financial Summary. Contractor shall specify in its request

the amount of the monthly CFA it is requesting, not to exceed \$621,473 for the first month and \$621,473 for the second month, if applicable. In no event shall the monthly CFA requested by Contractor exceed 1/12th of the annualized MCA as identified on Exhibit B – 6, Financial Summary, as of the specified month the CFA is requested.”

9. Financial Summary (Exhibit B – 6) for FY 2026-27 is added to the Contract for FY 2026-27, attached hereto and incorporated herein by reference.
10. Exhibit E (County’s Administration) is deleted in its entirety and replaced with Exhibit E – 6 (County’s Administration), attached hereto and incorporated herein by reference.
11. Contractor shall provide services in accordance with Contractor’s FY 2026-27 Service Delivery Plan for the Contract, and any addenda thereto approved in writing by the County’s Director of Mental Health, or designee.
12. Except as provided in this amendment, all other terms and conditions of the Contract will remain in full force and effect.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this amendment to be subscribed by County's Director of Mental Health, or designee, and Contractor has caused this amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
LISA H. WONG, Psy.D., Director
County of Los Angeles
Department of Mental Health

Telecare Corporation
CONTRACTOR

By _____
Name Dawan Utecht
Title SVP & CDO
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: RACHEL KLEINBERG
Senior Deputy County Counsel

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH CONTRACTOR CLAIMS
CERTIFICATION FOR TITLE XIX SHORT-DOYLE MEDI-CAL and TITLE XXI MEDICAID CHILDREN'S
HEALTH INSURANCE PROGRAM REIMBURSEMENTS

Contractor: Telecare Corporation

Legal Entity No.: 00108

Claims for services/activities with dates of services: 7/1/2026 through 6/30/2027.

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of the mental health services in and for said claimant; that the amounts for which reimbursement will be claimed for Medi-Cal and Medicaid Children's Health Insurance Program (MCHIP) services to be rendered during the above indicated fiscal year and to be claimed to the County of Los Angeles Department of Mental Health will be in accordance with the terms and conditions of the Contract; and that to the best of my knowledge and belief, each claim will be in all respects true, correct, and in accordance with State and federal law and regulation. I agree and certify under penalty of perjury that all claims for services to be provided to county mental health clients will be provided to the clients by this Contractor. The services will be provided in accordance with the client's written treatment plan. I agree and certify under penalty of perjury that no services will be submitted for the Contractor nor any of its staff members who is restricted, excluded, and/or suspended from providing services under any health care program funded by the federal government, directly or indirectly, in whole or in part. This certification covers staff members who are directly included on the claim or any staff member whose time is included on the claim, but whose identifying Name and National Provider ID are not included if they were a co-practitioner in the service. This Contractor also certifies that all information submitted to the County Department of Mental Health will be accurate and complete. This Contractor and I understand that payment of these claims will be from County, State and federal funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or State laws. The Contractor agrees to keep a printed representation of all records which must completely reflect the extent of services furnished to the client. The Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the County of Los Angeles Department of Mental Health, California Department of Health Care Services, Medi-Cal Fraud Unit; California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The Contractor also agrees that services will be offered and provided without discrimination based race and/or ethnicity, spirituality or religious affiliation, nationality, ancestry, preferred language, literacy, communication needs, gender identity, gender expression, age, marital or living partnership status, sexual orientation, physical and/or intellectual disability(ies), mental health condition(s), or medical condition(s).

FURTHER, I HEREBY CERTIFY under penalty of perjury to the following:

1. Services provided will be medically necessary as defined under DHCS BHIN 21-073.
2. The member will be determined to be eligible to receive Medi-Cal services at the time the services are provided to the member.
3. The services to be included in the claims will actually be provided to the member.
4. For any services that require authorization as indicated in DHCS BHIN 22-016, all authorization requirements will be met prior to service delivery.

Date: _____ Signature: _____

Executed at _____, California

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts. I further certify that this claimant will provide from the eligible designated funds in the Financial Summary of the DMH Contract with County, the local share of payment for Short-Doyle/Medi-Cal and/or MCHIP covered services to be included in the claims to be submitted to County during the above referenced period in order to satisfy matching requirements for federal financial participation pursuant to the Title XIX and Title XXI of the Social Security Act.

Date: _____ Signature: _____

Executed at _____, California

**24-Hour Programs - Organizational Providers
Financial Summary**

Contractor Name: Telecare Corporation Amendment No.: 6 Agreement No: MH570031
 Contractor No: MH570031 Fiscal Year: 2026-27 Fin Sum No: 6

A	B	C	D
Rank	Funded Program	Medi-Cal Reimbursable	Gross Allocation
Hospital and Acute Services			
1	Acute Psychiatric Inpatient	Medi-Cal (MC)	Y
2	Acute Psychiatric Inpatient	Non-MC	N
3	Acute Psychiatric Inpatient	Start-Up	N
4	Acute Psychiatric Inpatient	Client Support Funds	N
5	General Acute Care Hospital Inpatient	Medi-Cal (MC)	Y
6	General Acute Care Hospital Inpatient	Non-MC	N
7	General Acute Care Hospital Inpatient	Invoice	N
8	Professional Services	Medi-Cal (MC)	Y
9	Professional Services	Non-MC	N
10	Psychiatric Health Facility	Medi-Cal (MC)	Y \$ 5,593,260.00
11	Psychiatric Health Facility	Non-MC	N \$ 1,864,420.00
12	Psychiatric Health Facility	Start-Up	N
13	Psychiatric Health Facility	Client Support Funds	N
14	Psychiatric Health Facility Child/TAY (DCFS)	Non-MC	N
Subacute and Long-Term Care Services			
15	Mental Health Rehabilitation Center	Medi-Cal (MC)	Y
16	Mental Health Rehabilitation Center	Non-MC	N
17	Mental Health Rehabilitation Center	Start-Up	N
18	Mental Health Rehabilitation Center	Client Support Funds	N
Residential Treatment Services			
19	Enriched Residential Services	Medi-Cal (MC)	Y
20	Enriched Residential Services	Non-MC	N
21	Enriched Residential Services	Start-Up	N
22	Enriched Residential Services	Client Support Funds	N
Crisis Services			
23	Crisis Stabilization Unit Services	Medi-Cal (MC)	Y
24	Crisis Stabilization Unit Services	Non-MC	N
25	Crisis Stabilization Unit Services	Start-Up	N
26	Crisis Stabilization Unit Services	Client Support Funds	N
27	Children's Crisis Residential Programs	Medi-Cal	Y
28	Children's Crisis Residential Programs	Non-MC	N
29	Children's Crisis Residential Programs	Start-Up	N
30	Children's Crisis Residential Programs	Client Support Funds	N
31	Crisis Residential Treatment Program	Medi-Cal	Y
32	Crisis Residential Treatment Program	Non-MC	N
33	Crisis Residential Treatment Program	Start-Up	N
34	Crisis Residential Treatment Program	Client Support Funds	N
			Maximum Contract Amount (MCA) \$ 7,457,680.00

COUNTY'S ADMINISTRATION

CONTACT NAME: Telecare Corporation CONTRACT NO. MH570031

DIRECTOR OF MENTAL HEALTH:

Name: Lisa H. Wong, Psy.D

Title: Director

Address: 510 S. Vermont Avenue

Los Angeles, CA 90020

Telephone: (213) 947-6670

E-Mail Address: LWong@dmh.lacounty.gov

COUNTY MONITORING MANAGER:

Name: Paul Arns, Ph.D

Title: Deputy Director

Address: 510 S. Vermont Avenue, 20th Floor

Los Angeles, CA, 90020

Telephone: (213) 921-1818

E-Mail Address: PArns@dmh.lacounty.gov

CONTRACT LEAD:

Name: Yanela Soulier

Title: Administrative Services Manager III

Address: 510 S. Vermont Avenue, 20th Floor

Los Angeles, CA, 90020

Telephone: (213) 943-8210

E-Mail Address: YSoulier@dmh.lacounty.gov

COUNTY CONTRACT ADMINISTRATOR

Name: Beatriz Torres

Title: Administrative Services Manager I

Address: 510 S. Vermont Avenue, Los Angeles, CA 90020

Telephone: (213) 943-9177

E-Mail Address: BeTorres@dmh.lacounty.gov



DEPARTMENT OF MENTAL HEALTH
 hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
 Director

Curley L. Bonds, M.D.
 Chief Medical Officer

Rimmi Hundal, M.A.
 Chief Deputy Director

April 3, 2026

TO: Supervisor Hilda L. Solis, Chair
 Supervisor Holly J. Mitchell
 Supervisor Lindsey P. Horvath
 Supervisor Janice Hahn
 Supervisor Kathryn Barger

FROM: Lisa H. Wong, Psy.D.
 Director

R Hundal

SUBJECT: **NOTICE OF INTENT TO EXECUTE A SOLE SOURCE AMENDMENT TO EXTEND THE EXISTING CONTRACT WITH TELECARE CORPORATION FOR ADULT PSYCHIATRIC HEALTH FACILITY SERVICES AT THE MARTIN LUTHER KING JR. BEHAVIORAL HEALTH CENTER**

In accordance with the Los Angeles County Board of Supervisors' (Board) Policy No. 5.100 (Sole Source Contracts and Amendments), the Department of Mental Health (DMH) intends to amend the existing contract with Telecare Corporation for Adult Psychiatric Health Facility (PHF) Services at the Martin Luther King Jr. Behavioral Health Center.

DMH will request that your Board approve a sole source extension amendment with Telecare Corporation, effective July 1, 2026, through June 30, 2027, with one optional year. The Maximum Contract Amount for Fiscal Year 2026-27 is \$7,457,680 fully funded by PHF Funding as the current contracts is due to expire on June 30, 2026. The current contract was awarded to Telecare Corporation in 2024 as a result of a competitive solicitation.

JUSTIFICATION

Telecare Corporation for Adult PHF is a facility with 16 beds for adults and provides an alternative to acute hospital care. The 24-hour inpatient services in PHF are designed to provide innovative and comprehensive acute care services in a more home-like environment for members with mental health disorders with Medi-Cal and Non Medi-Cal

Each Supervisor
April 3, 2026
Page 2

benefits as an alternative to hospital care. Members receive therapeutic services such as vocational, interpersonal, and independent living skills to become more self-sufficient and capable of increasing levels of independent functioning.

DMH intends to extend the current 24-Hour Residential Treatment Program Contract with Telecare Corporation for Adult PHF at Martin Luther King Jr. Behavioral Health Center. The extension of this contract ensures that vulnerable clients do not experience a disruption in vital mental health services. Telecare Corporation is already fully credentialed, adequately staffed, and seamlessly integrated into the facility's operations and Electronic Health Record system. It is in the County's best economic interest to continue the existing contract with Telecare Corporation as bringing in a new vendor at this stage would require a lengthy transition period that would compromise patient safety and regulatory compliance. Operating a PHF requires strict adherence to Department of Health Care Services licensing standards.

NOTIFICATION TIMELINE

Pursuant to Board Policy No. 5.100 (Sole Source Contracts and Amendments), DMH is required to notify the Board at least six months prior to the expiration of an existing contract when the Department does not have delegated authority to execute such amendment. DMH is late in submitting this notification due in part to an oversight that occurred while the Department has been managing the transition from the Mental Health Services Act to the Behavioral Health Services Act. If requested by a Board Office or the Chief Executive Office, DMH will place this item on the Health and Mental Health Services Cluster Agenda.

Unless otherwise instructed by your Board Office within two weeks of this notice, DMH will present to your Board a letter for approval to execute an amendment to the existing contract with Wolf Connection.

If you have any questions or require additional information, please contact me by email at LWong@dmh.lacounty.gov or (213) 947-6670, or your staff may contact Stella Krikorian, Division Manager, Contracts Development and Administration Division, at SKrikorian@dmh.lacounty.gov or (213) 943-9146.

LHW:RH:KN
SK:HB:atm

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

SOLE SOURCE CHECKLIST

Department Name: _____

- New Sole Source Contract
- Sole Source Amendment to Existing Contract

Date Existing Contract First Approved: _____

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS AND AMENDMENTS Identify applicable justification and provide documentation for each checked item.
	➤ Only one bona fide source (monopoly) for the service exists; performance and price competition are not available. A monopoly is an <i>“Exclusive control of the supply of any service in a given market. If more than one source in a given market exists, a monopoly does not exist.”</i>
	➤ Compliance with applicable statutory and/or regulatory provisions.
	➤ Compliance with State and/or federal programmatic requirements.
	➤ Services provided by other public or County-related entities.
	➤ Services are needed to address an emergent or related time-sensitive need.
	➤ The service provider(s) is required under the provisions of a grant or regulatory requirement.
	➤ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
	➤ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
	➤ Maintenance service agreements exist on equipment which must be serviced by the original equipment manufacturer or an authorized service representative.
	➤ It is more cost-effective to obtain services by exercising an option under an existing contract.
	➤ It is in the best economic interest of the County (e.g., significant costs and time to replace an existing system or infrastructure, administrative cost and time savings and excessive learning curve for a new service provider, etc.). In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Chief Executive Office

Date



DEPARTMENT OF MENTAL HEALTH
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LISA H. WONG, Psy.D.
 Director

Curley L. Bonds, M.D.
 Chief Medical Officer

Rimmi Hundal, M.A.
 Chief Deputy Director

April 10, 2026

TO: Supervisor Hilda L. Solis, Chair
 Supervisor Holly J. Mitchell
 Supervisor Lindsey P. Horvath
 Supervisor Janice Hahn
 Supervisor Kathryn Barger

FROM: Lisa H. Wong, Psy.D. *RHundal*
 Director

SUBJECT: **REQUEST AN EXEMPTION TO BOARD POLICY NO 5.120 FOR
 TELECARE CORPORATION FOR ADULT PSYCHIATRIC HEALTH
 FACILITY SERVICES AT THE MARTIN LUTHER KING JR.
 BEHAVIORAL HEALTH CENTER**

In accordance with Los Angeles County Board of Supervisors' (Board) Policy No. 5.120 (Authority to Approve Increases to Board Approved Contract Amounts), the Department of Mental Health (DMH) is notifying your Board of our Department's intent to request delegated authority for a percentage increase exceeding ten percent of the Maximum Contract Amount (MCA) for the existing Contract with Telecare Corporation for the Adult Psychiatric Health Facility (PHF) Services at the Martin Luther King Jr. Behavioral Health Center. More specifically, DMH will request delegated authority for a 25 percent increase for the term of the extension.

JUSTIFICATION

DMH will present to your Board a letter for approval to extend the existing Contract with Telecare Corporation for Adult PHF Services at the Martin Luther King Jr. Behavioral Health Center. Approval of this request will ensure the continued provision of 24-hour inpatient care services in a PHF for clients with mental health disorders, designed to provide innovative and comprehensive acute care services in a more home-like environment for Medi-Cal and Non Medi-Cal clients as an alternative to hospital care.

Each Supervisor
April 10, 2026
Page 2

Clients will receive therapeutic services such as vocational, interpersonal, and independent living skills to become more self-sufficient and capable of increasing levels of independent functioning.

NOTIFICATION TIMELINE

Pursuant to Board Policy No. 5.120 (Authority to Approve Increases to Board-Approved Contract Amounts), DMH is required to notify your Board at least two weeks prior to the Board Meeting at which the request to exceed ten percent of the MCA will be presented. In accordance with this policy, DMH is notifying your Board of its intent to request delegated authority to increase the MCA by up to 25 percent. This request will be presented through a Board letter at the June 9, 2026, Board Hearing.

If you have any questions or require additional information, please contact me at LWong@dmh.lacounty.gov or (213) 947-6670, or your staff may contact Stella Krikorian, Division Manager, Contracts Development and Administration Division, at SKrikorian@dmh.lacounty.gov or (213) 943-9146.

LHW:RH:KN
SK:HB:atm

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

**BOARD LETTER/MEMO
CLUSTER FACT SHEET**

Board Letter

Board Memo

Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input checked="" type="checkbox"/> All <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Mental Health	
SUBJECT	Request approval to extend the term of the existing Public Partnership for Wellbeing contract with The Regents of the University of California, Los Angeles, on a sole source basis.	
PROGRAM	Public Partnership for Wellbeing (PPFW) contract with The Regents of University of California, Los Angeles (The Regents)	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain why: Services provided by other public or County-related entities.	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Not Applicable Not applicable.	
DEADLINES/ TIME CONSTRAINTS	06/09/2026	
COST & FUNDING	Total cost: \$17,092,280	Funding source: Behavioral Health Services Act (BHSA) Workforce Education and Training (WET)-Training and Technical Assistance (TTA), BHSA Innovation (INN) Program Improvements for Valued Outpatient Treatment (PIVOT), and 2011 Realignment - Mental Health revenues TERMS (if applicable): 07/01/2026 – 06/30/2027 Explanation: BHSA-WET: \$10,572,264, BHSA-INN PIVOT: \$3,988,149, and 2011 Realignment: \$2,531,867
PURPOSE OF REQUEST	Extend the existing PPFW contract with The Regents for one fiscal year to continue provision of the following services to psychology post-doctoral clinicians, psychiatry residents, fellows, and other advanced trainees. 1) Education & Training, 2) Training and Technical Assistance, 3) Innovation and Technology.	
BACKGROUND (include internal/external issues that may exist including any related motions)	On June 18, 2019 The Board approved the existing sole source contract with The Regents for the provision of services mentioned above. The existing contract is set to expire on June 30, 2026. Continuous provision of services are needed for Fiscal Year 2026-27 while DMH develops and negotiates a new sole-source contract with The Regents.	
EQUITY INDEX OR LENS WAS UTILIZED	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain how: The racial equity principles framework was applied by focusing on reducing disparities, engaging residents, disaggregating data, and aligning policies and practices to address inequities. Decision making and resource allocation are guided by policy alignment to prioritize equity, ensuring resources are directed to communities most impacted by disparities and that that investment support measurable equitable outcomes.	
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state which one(s) and explain how: The request supports several of the Board Priorities, particularly Health Integration, Care First/ Jail Last, Homelessness, Anti-Racism, and Poverty Alleviation. The initiative advances integrated, community-based mental health services that prioritize prevention and equitable access to care, reduce the need for justice involved systems and address the needs of individuals experiencing homelessness. Additionally, it centers and targets resources to our population disproportionately impacted by systemic inequities and poverty, aligning with the county's commitment to improving outcomes for vulnerable communities	
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Curley Bonds II, M.D. Medical Director , (213) 738-4108 , CBonds@dmh.lacounty.gov , Anna Bruce, Mental Health Program Manager II, (213) 943-9983 , ABruce@dmh.lacounty.gov Rachel Kleinberg, Senior Deputy County Counsel, (213) 392-6668, RKleinberg@counsel.lacounty.gov Stella Krikorian, Administrative Services Division Manager DMH Contracts, (213) 943-9146, SKrikorian@dmh.lacounty.gov ,	



DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

**APPROVAL TO EXTEND THE EXISTING PUBLIC PARTNERSHIP FOR WELLBEING
CONTRACT WITH THE REGENTS OF THE UNIVERSITY OF CALIFORNIA ON
BEHALF OF ITS LOS ANGELES CAMPUS ON A SOLE SOURCE BASIS
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

SUBJECT

Request approval to extend the term of the existing Public Partnership for Wellbeing contract with The Regents of the University of California, Los Angeles, on a sole source basis.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or designee, to prepare, sign, and execute an amendment, substantially similar to Attachment I, to the existing Public Partnership for Wellbeing (PPFW) contract with The Regents of University of California, Los Angeles (The Regents) for one fiscal year, July 1, 2026, through June 30, 2027. The funding for the extension period will be \$17,092,280 fully funded by Behavioral Health Services Act (BHSA) Workforce Education and Training (WET)-Training and Technical Assistance (TTA), BHSA Innovation (INN) Program Improvements for Valued Outpatient Treatment (PIVOT), and 2011 Realignment - Mental Health revenues. The revised Total Contract Amount (TCA) will be \$132,886,966.
2. Delegate authority to the Director, or designee, to prepare, sign, and execute future amendments to the contract in Recommendation 1; to extend the contract term for

one additional year if necessary; revise the TCA; revise contract language; shift unspent funds to future fiscal year; add, delete, modify, or replace the Statement of Work/Service Exhibits; and/or reflect federal, State, and County regulatory and/or policy changes provided that: 1) any increase will not exceed 10 percent of the Board-approved TCA indicated in Recommendation 1; and 2) sufficient funds are available. These amendments will be subject to prior review and approval as to form by County Counsel, with written notice to the Board and the Chief Executive Office (CEO).

3. Delegate authority to the Director, or designee, to terminate the contract described in Recommendation 1 in accordance with the termination provisions of the contract, including Termination for Convenience. The Director, or designee, will provide written notification to your Board and CEO of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

The Regents, as a public entity, will continue to deliver the comprehensive services envisioned by Department of Mental Health (DMH), drawing on their academic leadership, clinical training expertise, research capabilities, and long-standing history of collaboration with the Department. These strengths ensure continuity of care and support the advancement of clinical services. Extending the contract term with The Regents will maintain the Department's comprehensive training pipeline and continue providing in-depth didactics for psychology post-doctoral clinicians, psychiatry residents, fellows, and other advanced trainees who play a critical role in delivering mental health services within DMH's directly operated clinics, programs, and contracted providers. Additionally, continuous access to The Regents' robust educational infrastructure enables DMH to strengthen clinical competencies across the workforce and align with Behavioral Health Services Act priorities, including Co-occurring Disorder integration, evidence-based practices, and Full-Service Partnership/Intensive Case Management service expectations.

Board approval of Recommendation 1 will allow DMH to extend the term for the existing PPFW Contract with The Regents on a sole source basis, for the continued provision of Education and Training, Training and Technical Services, and Innovation and Technology services to psychology post-doctoral clinicians, psychiatry residents, fellows, and other advanced trainees within DMH's directly operated clinics and/or contracted providers, while DMH develops and negotiates a new sole-source contract with The Regents.

Board approval of Recommendation 2 will allow DMH to amend the contract in Recommendation 1 to extend the contract term if needed and reflect on other necessary changes in a timely manner for the continued provision of services without interruption.

Board approval of Recommendation 3 will allow DMH to terminate the contract in Recommendation 1 in accordance with the contract's termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the County's Strategic Plan North Star 1, Make Investments that Transform Lives, specifically Focus Area Goal B – Employment and Sustainable Wages, North Star 3, Realize Tomorrow's Government Today, specifically Focus Area Goal A – Communication and Public Access and Focus Area Goal E – Data Driven Decision Making.

FISCAL IMPACT/FINANCING

The allocated amount for Fiscal Year (FY) 2026-27 is \$17,092,280 fully funded by BHSA WET-TTA, BHSA INN PIVOT, and 2011 Realignment - Mental Health revenues.

Sufficient appropriation is included in DMH's FY 2026-27 annual budget.

There is no net County cost impact associated with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

This collaboration with The Regents uniquely integrates accredited psychiatry and psychology training programs with community-based workforce development, ensuring continuity of care and alignment with BHSA. The scope of services includes the following:

Education and Training: Integrates accredited psychiatry, psychology, and neuropsychology training programs with DMH clinics, while launching a Public and Community Psychiatry Fellowship to develop early-career psychiatric leaders serving under-resourced communities. Supports specialized initiatives-including the National Clinician Scholars Program, Conservatorship Assessment Training, and bilingual clinical training-focused on equity, cultural and linguistic competence, and advanced education for post-doctoral clinicians, residents, and fellows.

Training and Technical Assistance: Operates the Public Mental Health Partnership to serve individuals with serious mental illness, co-occurring disorders, homelessness, and justice involvement, while providing specialized training and practice-based-evaluation. Reinstates the statewide Integrated Care Conference to support professionals through the Mental Health Services Act-to-Behavioral Health Services Act transition. Coordinates data integration among the California Policy Lab, Los Angeles County InfoHub, and DMH to enable advanced analytics for program design and evaluation, aligning training with

Behavioral Health Transformation priorities. The Behavioral Health Center of Excellence functions as a countywide hub that enhances the behavioral health workforce and promotes evidence-based-practices for children, youth, and families through training, consultation, and implementation support.

Innovation and Technology: Maintains a proprietary Learning Management System (LMS) developed with DMH which integrates all PPFW programs into one platform; supports live/asynchronous training and learning communities; and provides automated tracking, reporting, and continuing education. LMS is mission-critical, non-commercially available, and replacing it would require costly redevelopment and risk service disruption.

The PPFW contract allows The Regents to combine its nationally accredited psychiatry and psychology training programs with hands-on workforce development in Los Angeles County's public mental health system. This creates a pipeline of highly trained professionals who are prepared to work in community settings.

Since inception of the contract with The Regents, a total of 282,694 PPFW trainings and courses have been completed by providers and community members across the County including the Departments of Health Services, Children and Family Services and Public Health. With over 68,907 active users on the DMH and UCLA Wellbeing for Los Angeles Learning Center, DMH in collaboration with The Regents plan to expand the menu of training (in-person and live virtual) and resources that support and create professional, community, and peer training opportunities across the County's diverse ecosystems. In FY 2024-25, providers and community members across the County completed 54,373 PPFW training courses, representing over 50,898 training hours. In FY 2025-26, as of the second quarter, providers and community members across Los Angeles County completed 29,535 PPFW trainings and courses.

In accordance with Board Policy No. 5.100 (Sole Source Contracts and Amendments to Extend Contracts), DMH notified your Board (Attachment II) of our intent to extend the contract term with The Regents for one fiscal year on a sole source basis, and as we did not hear otherwise, DMH is moving forward with this action. The required Sole Source Checklist (Attachment III), identifying and justifying the need for this sole source contract has been approved by the CEO.

In accordance with AB 339 reporting requirements, DMH has submitted the required notification to the appropriate party within the County.

The Amendment (Attachment I) has been approved as to form by County Counsel.

The Honorable Board of Supervisors
June 9, 2026
Page 5

As mandated by your Board, the performance of this contract is evaluated by DMH on an annual basis to ensure compliance with all contract terms and performance standards.

IMPACT ON CURRENT SERVICES OR PROJECTS

Board approval of the recommended actions will allow DMH to maintain and expand the services provided by The Regents under the PPFW contract, thus enabling DMH to strengthen clinical competencies across the workforce throughout the County.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:RH:KN:SK:CM:atm

Attachments (3)

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

CONTRACT NO. MH270001

AMENDMENT NO. 23

THIS AMENDMENT is made and entered into this xx day of June 2026, by and between the COUNTY OF LOS ANGELES (hereafter "County"), and The Regents of The University of California, on behalf of its Los Angeles Campus (hereafter "Contractor").

WHEREAS reference is made to that certain document entitled "Public Partnership for Wellbeing Contract", dated July 1, 2019, and further identified as County Contract No. MH270001, and any amendments hereto (hereafter collectively "Contract"); and

WHEREAS, on June xx, 2026, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute an amendment to the Contract to add/delete/revise language, modify or replace the existing Statement of Work (SOW), revise the Total Contract Amount (TCA), and make certain designated changes; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

WHEREAS, County and Contractor intend to amend this Contract only as described hereunder; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of the Contract, and consistent with the professional standard of care for these services.

NOW, THEREFORE, County and Contractor agree as follows:

1. This amendment is hereby incorporated into the original Contract, and all its terms and conditions, including capitalized terms defined therein, will be given full force and effect as if fully set forth herein.
2. This amendment is effective July 1, 2026.
3. The term of the Contract is extended for one-year effective July 1, 2026, and will continue in full force through June 30, 2027.
4. A total of \$143,256 in funding is added to Public Partnership for Wellbeing (PP4W) Joint Mental Health Oversight Committee SOW, Exhibit A, Attachment 3-23, to Paragraph 6.0 (Budget) for Fiscal Year (FY) 2026-27 as follows:

“6.0 Budget

6.1 For the services described in this Exhibit, DMH will pay UCLA in accordance with the following:

Category	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
PP4W Director Salary	\$123,447	\$123,447	\$123,447	\$123,447	\$123,447	\$123,447	\$123,447	\$123,447
Other Direct Costs:	\$ 1,124	\$ 1,124	\$ 1,124	\$ 1,124	\$ 1,124	\$ 1,124	\$1,124	\$1,124
Indirect Costs: 15% of total direct costs.	\$ 18,686	\$ 18,686	\$ 18,686	\$ 18,686	\$ 18,686	\$ 18,686	\$18,686	\$18,686
Annual Total:	\$143,256	\$143,256	\$143,256	\$143,256	\$143,256	\$143,256	\$143,256	\$143,256”

5. A total of \$2,211,818 in funding is added to Trainees SOW, Exhibit A-A.1-23, to Paragraph 12 (BUDGET) for FY 2026-27 as follows:

“12. BUDGET

12.1 For the services described in this SOW, DMH will pay UCLA in accordance with the following:

Trainee SOW Budget

Category	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
Trainees (Residents and ACGME-approved Fellows)	\$255,767	\$255,767	\$255,767	\$362,715	\$362,715
Public Psychiatry Fellows	\$ -	\$ -	\$ -	\$	\$385,853
Public Psychiatry Personnel	\$ -	\$ -	\$ -	\$524,368	\$1,037,016
Public Psychiatry Other	\$ -	\$ -	\$ -	\$7,008	\$28,689
PI Oversight of Trainee SOW (Katrina DeBonis)	\$ -	\$ -	\$ -	\$ 55,000	\$55,000
GME Program Administration	\$ -	\$ -	\$ -	\$21,151	\$21,151
Other direct Costs	\$4,956	\$4,956	\$4,956	\$8,223	\$8,223
Travel: Mileage reimbursement at .58 cents per mile	\$14,578	\$14,578	\$14,578	\$14,673	\$24,673
Total Direct Cost:	\$275,301	\$ 275,301	\$275,301	\$993,139	\$1,923,320
Indirect Costs: 15% of total direct costs. (GME +Public Psychiatry)	\$41,295	\$41,295	\$41,295	\$148,970	\$288,498
Annual Total:	\$316,596	\$316,596	\$316,596	\$1,142,109	\$2,211,818”

6. Trainees SOW – Exhibit A-A.1-21, Attachment 1 (Administration of Contract/SOW) is deleted in its entirety and replaced with “Exhibit A-A.1-23, Attachment 1 (Administration of Contract/SOW)” attached hereto and incorporated herein by reference. All references to “Exhibit A-A.1-21, Attachment 1 (Administration of Contract/SOW)” will be deemed amended to state “Exhibit A-A.1-23, Attachment 1 (Administration of Contract/SOW)”
7. A total of \$225,700 in funding is added to National Clinician Scholars Program (NCSP) SOW, Exhibit A-A2.23, to paragraph 11 (Funding) for FY 2026-27 as follows:

“11.0 FUNDING

- 11.1 For the services outlined in this SOW, DMH will pay the Contractor according to the table below.

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25			FY2025-26			FY 2026-27
						Year Two-Fellow	Year One-Fellow	TOTAL FY 2024-25	Year Two Fellow	Year Two Fellow	TOTAL FY 25-26	Year Two Fellow
Clinician Scholar: includes the cost of one Scholar and a Faculty Mentor.	\$95,909	\$108,513	\$108,513	\$98,337	\$112,900	\$123,511	\$117,360	\$240,871	\$142,446	\$71,644	\$214,090	\$142,446
UCLA Faculty/Personnel	\$3,102	\$3,102	\$3,102	\$2,760	\$6,000	\$6,000	\$0	\$6,000	\$6,000	\$0	\$6,000	\$6,000
Materials and Supplies: includes books, projects supplies, other expenses etc.	\$41,815	\$41,815	\$41,815	\$36,844	\$55,029	\$41,315	\$0	\$41,315	\$41,315	\$0	\$41,315	\$41,315
Research Project Related Travel	\$1,000	\$1,000	\$1,000	\$800	\$500	\$500	\$0	\$500	\$500	\$0	\$500	\$500
Conference Travel: National Clinician Scholars Program Annual Meeting & 1 to 2 Scientific meetings per year.	\$3,600	\$3,600	\$3,600	\$3,200	\$3,100	\$3,100	\$0	\$3,100	\$6,000	\$0	\$6,000	\$6,000
Indirect Costs: 15% of total direct costs.	\$21,814	\$21,814	\$21,814	\$20,600	\$26,630	\$26,164	\$17,604	\$43,768	\$29,439	\$10,747	\$40,186	\$29,439
Annual Total:	\$167,240	\$179,844	\$179,844	\$162,541	\$204,159	\$200,590	\$134,964	\$335,554	\$225,700	\$82,391	\$308,091	\$225,700

8. A total of \$802,820 in funding is added to Los Angeles County Office of the Public Guardian - CAT Team SOW - Exhibit A-A.3-23, to Paragraph 11 (Funding) for FY 2026-27 as follows:

“11.0 FUNDING

11.1 For the services outlined in this SOW, DMH will pay the Contractor according to the table below:

Category	FY 2024-25 (6 Months)	FY 2025-26	FY 2026-27
Personnel	\$307,461	\$614,923	\$614,923
Travel	\$0	\$10,000	\$10,000
Materials & Supplies	\$15,071	\$30,141	\$30,141
Research Support	\$9,929	\$19,859	\$19,859
Consultant	\$7,500	\$15,000	\$15,000
UCLA TIF	\$1,042	\$2,084	\$2,084
UCLA GAEL	\$3,049	\$6,097	\$6,097
Total Direct Cost	\$344,052	\$698,104	\$698,104
Indirect Cost: 15% of total direct costs	\$51,608	\$104,716	\$104,716
Total	\$395,660	\$802,820	\$802,820"

9. CAT SOW – Exhibit A-A.3-20, Attachment 1 (Administration of Contract/SOW) is deleted in its entirety and replaced with “Exhibit A-A.3-23, Attachment 1 (Administration of Contract/SOW)” attached hereto and incorporated herein by reference. All references to “Exhibit A-A.3-20, Attachment 1 (Administration of Contract/SOW)” will be deemed amended to state “Exhibit A-A.3-23, Attachment 1 (Administration of Contract/SOW)”
10. A total of \$7,233,586 in funding is added to Prevention Center of Excellence: Trauma and Resilience Informed Training Program SOW, Exhibit A-B.2-23, to Paragraph 11 (Rates and Payment Procedures) for FY 2026-27 as follows:

“11.0 RATES AND PAYMENT PROCEDURES

For deliverables and tasks that are not completed within any given fiscal year, Contractor may request approval from DMH to complete those tasks in subsequent fiscal years and DMH may roll over the funds associated with the completion of such deliverables and tasks. The roll-over of funds is subject to funding availability and may require an Amendment.

DMH will pay UCLA in accordance with the following:

Category	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY2025-26	FY2026-27
Senior Personnel	\$820,789	\$606,583	\$716,093	\$716,093	\$716,093	\$716,093
Other Personnel	\$3,997,483	\$4,168,219	\$ 4,482,509	\$4,482,509	\$4,482,509	\$4,482,509
Other Direct Costs	\$1,740,593	\$1,725,450	\$1,085,263	\$1,085,263	\$1,085,263	\$1,085,263
Travel	\$6,210	\$7,020	\$6,210	\$6,210	\$6,210	\$6,210
Indirect Costs: 15% of total direct costs.	\$984,761	\$976,091	\$ 943,511	\$ 943,511	\$943,511	\$943,511
Annual Total:	\$7,549,836	\$7,483,363	\$7,233,586	\$7,233,586	\$7,233,586	\$7,233,586

11. Prevention Center of Excellence: Trauma and Resilience Informed Training Program SOW, Exhibit A-B.2-13, Attachment 1 (Administration of Contract/SOW) is deleted in its entirety and replaced with “Exhibit A-B.2-23, Attachment 1 (Administration of Contract/SOW)” attached hereto and incorporated herein by reference. All references to “Exhibit A-B.2-13, Attachment 1 (Administration of Contract/SOW)” will be deemed amended to state “Exhibit A-B.2-23, Attachment 1 (Administration of Contract/SOW)”
12. A total of \$4,288,149 in funding is added to Public Mental Health Partnership and California Policy Lab SOW, Exhibit A-B.3-23, to Paragraph 14 (Funding and Deliverables) for FY 2026-27 as follows:

“14.0 FUNDING AND DELIVERABLES

For the PMHP services described in this SOW, DMH will pay UCLA in accordance with the following:

Category	HS-TTA	MHCS-TTA	FY 2024-25	FY2025-26	FY2026-27
Personnel	\$1,018,012	\$1,726,099	\$2,744,111	\$2,744,111	\$2,744,111
Consultant	\$287,450	\$76,850	\$364,300	\$364,300	\$364,300
Supplies	\$4,609	\$4,609	\$9,218	\$9,218	\$9,218
Travel	\$737	\$737	\$1,474	\$1,474	\$1,474
Other	\$13,747	\$295,975	\$309,722	\$309,722	\$309,722
Integrated Care Conference	\$0	\$0	\$0	\$300,000	\$300,000
Other-SAMHSA	\$0	\$0	\$310,500	\$77,759.64	\$0
Subcontracts	\$0	\$0	\$0	\$0	\$0
TOTAL DIRECT COST	\$1,324,554	\$2,104,270	\$3,739,325	\$3,806,585	\$3,728,825
INDIRECT COST: 15% of total direct costs.	\$198,683	\$315,640	\$560,899	\$570,988	\$559,324
Annual Total:	\$1,523,237	\$2,419,910	\$4,300,224	\$4,377,573	\$4,288,149

The deliverable fee schedule above is included for DMH’s reference only. Contractor agrees to submit milestone-based invoices in accordance with the above schedule for the PMHP. Actual Contractor expense shall be submitted to DMH in accordance with the following major budget categories for PMHP:

Faculty Coaching & Consultation under Section 3.2: For services described in this section, DMH shall pay Contractor an amount not to exceed \$66,240 annually in accordance with the rates set forth below:	
SERVICE	RATE
Supervision (2-4 hours)	\$600/session + overhead @ 15%
Consultation & Coaching	\$600 per hour + overhead @ 15%
Half-day didactic training	\$2,000 + overhead @ 15%
Full-day didactic training	\$4,000 + overhead @ 15%”

- A total of \$2,186,951 in funding is added to Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T) SOW, Exhibit A-B.4-23, to Paragraph 11.0 (Funding/Fee Scheule) for FY 2026-27 as follows:

“11.0 FUNDING/FEE SCHEDULE

11.1 For the services outlined in this SOW, LACDMH will pay UCLA in accordance with the following:

Category	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27
Trainees	\$ 38,127	\$ 345,338	\$ 935,339	\$ 935,339	\$ 935,339
UCLA Faculty/Personnel	\$ 445,912	\$ 553,352	\$ 692,709	\$ 692,709	\$ 692,709
Other direct costs: cost reimbursement for program supplies, computers, equipment, Neuropsych assessments, printing and copy maintenance etc.	\$ 26,400	\$ 69,775	\$ 82,900	\$ 82,900	\$ 82,900
General, Automobile, and Employment Practices Liability (GAEL)	\$ 4,741	\$ 8,596	\$ 20,116	\$ 20,116	\$ 20,116
Technology Infrastructure Fee (TIF)	\$ 1,478	\$ 2,664	\$ 4,632	\$ 4,632	\$ 4,632
Travel to Annual Professional Meetings: \$2,000 cost per trip for each neuropsychology trainee (2 trainees)	\$ -	\$ 4,000	\$ 16,000	\$ 16,000	\$ 16,000
Consultant Services: including subcontract for production of videos	\$ 230,000	\$ 290,000	\$ 140,000	\$ 140,000	\$ 140,000
BASIC-T Annual Retreat	\$ -	\$ 10,000	\$ 10,000	\$ 10,000	\$ 10,000
Total Direct Costs	\$ 746,658	\$1,283,725	\$ 1,901,697	\$ 1,901,697	\$ 1,901,697
Indirect Costs: 15% of total direct costs	\$ 111,998	\$ 192,558	\$ 285,255	\$ 285,255	\$ 285,255
Annual Total:	\$ 858,656	\$1,476,283	\$ 2,186,951	\$ 2,186,951	\$ 2,186,951

14. BASIC-T SOW, Exhibit A-B.4-20 Attachment 1 (Administration of Contract/SOW) is deleted in its entirety and replaced with "Exhibit A-B.4-23, Attachment 1 (Administration of Contract/SOW)" attached hereto and incorporated herein by reference. All references to "Exhibit A-B.4-20, Attachment 1 (Administration of Contract/SOW)" will be deemed amended to state "Exhibit A-B.4-23, Attachment 1 (Administration of Contract/SOW)".
15. A total of \$17,092,280 in funding is added to FY 2026-27, increasing the TCA from \$115,794,686 to \$132,886,966.
16. Exhibit B-22 (Funding Summary) will be revised and replaced with "Exhibit B-23 (Funding Summary)" attached hereto and incorporated herein by reference. All

references to "Exhibit B-22" will be deemed amended to state "Exhibit B-23 (Funding Summary)".

17. Except as provided in this amendment, all other terms and conditions of the Contract will remain in full force and effect.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this amendment to be subscribed by County's Director of Mental Health or designee, and Contractor has caused this amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
LISA H. WONG, Psy.D., Director
County of Los Angeles
Department of Mental Health

The Regents of The University
of California, on behalf of its
Los Angeles Campus
CONTRACTOR

By _____
Name: Julia Zhu
Title: Assistant Director

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: RACHEL KLEINBERG
Senior Deputy County Counsel

**EXHIBIT A-A.1-23 (TRAINEES) – ATTACHMENT 1
ADMINISTRATION OF SOW**

GE SERVICES PRINCIPAL INVESTIGATOR (PI)

Name: Katrina DeBonis

Title: Associate Health Sciences Clinical Professor and Vice Chair of
Education, Psychiatry and Biobehavioral Sciences

Address: 300 UCLA Medical Plaza, Suite 2341, Los Angeles, CA 90095

Telephone: (310) 206-1596

E-Mail Address: kdebonis@mednet.ucla.edu

Name: Roya Ijadi-Maghsoodi, MD, MSHPM

Title: Child, Adolescent, and Adult Psychiatry Director, UCLA Public and Community
Psychiatry Fellowship Assistant Professor-in- Residence

Address: _____

Telephone: _____

E-Mail Address: rijadimaghsoodi@mednet.ucla.edu

DMH PROGRAM LEAD

Name: Katherine Smith-White, M.D.

Title: Associate Medical Director- Academic

Address: 510 S. Vermont Ave., 22nd Floor, Los Angeles, CA 90020

Telephone: (818) 256-2243

E-Mail Address: ksmith-white@dmh.lacounty.gov

Exhibit A - A.3 - 23
Los Angeles County Office of the Public Guardian — Conservatorship
Assessment Training (CAT) Team UCLA Response Team
ADMINISTRATION OF SOW

PRINCIPAL INVESTIGATOR (PI)

Name: Diomaris E. Safi

Title: Director, Justice in Criminal Neuropsychology Program

Hispanic Neuropsychiatric Center of Excellence

Address: 760 Westwood Plaza, C7-406, Los Angeles, CA 90095

Telephone: (310) 794-2479

E-Mail Address: Dsafi@mednet.ucla.edu

Name: _____

Title: _____

Address: _____

Telephone: _____

E-Mail Address: _____

DMH PROGRAM LEAD

Name: Luis Leyva

Title: Division Chief, Public Guardian

Address: 510 S. Vermont Ave., 19th Floor, Los Angeles, CA 90020

Telephone: (213) 943-9553

E-Mail Address: LLeyva@dmh.lacounty.gov

ADMINISTRATION OF SOW

PRINCIPAL INVESTIGATOR

Name: Catherine Mogil

Title: Associate Clinical Professor, Psychiatry, David Geffen School of Medicine

Address: 760 Westwood Plaza, A8--225
Los Angeles, CA 90095

Telephone: (310) 794-3518

E-Mail Address: cmogil@mednet.ucla.edu

PI DESIGNATED ALTERNATE

Name: Norweeta Milburn, PhD

Title: Professor-in-Residence

Address: 760 Westwood Plaza, A8-153
Los Angeles, CA 90095

Telephone: (310) 794-3773

Mail Address: NMilburn@mednet.ucla.edu

DMH PROGRAM LEAD

Name: Kanchana Tate

Title: MH Program Manager II

Address: 510 S. Vermont Ave 22nd Floor, Los Angeles, CA 90020

Telephone: (213) 943-9765

E-Mail Address: ktate@dmh.lacounty.gov

**Exhibit A - B.4-23 (BASIC-T)
ADMINISTRATION OF SOW**

PRINCIPAL INVESTIGATOR (PI)

Name: Jasper A. Estabillo, PhD
Title: Program Director, UCLA-LACDMH BASIC-T
Address: 760 Westwood Plaza, C8-222 (HNCE), Los Angeles, CA 90095
Telephone: _____
E-Mail Address: _____

CO-PRINCIPAL INVESTIGATOR

Name: Paola Suarez
Title: Supervisor & Director of Cultural Neuropsychology Program (CNP)
Address: 760 Westwood Plaza, C8-232, Los Angeles, CA 90095
Telephone: (310) 206-7313 Facsimile: (310) 206-1109
E-Mail Address: psuarez@mednet.ucla.edu

DMH PROGRAM LEAD

Name: Anna Bruce, LCSW, MPA / Lisa Wong, Psy.D.
Title: Acting Assistant Administrative Deputy/ Director MH (Respectively)
Address: 510 S. Vermont Ave., 21st Floor, Los Angeles, CA 90020
Telephone: (213) 943-9983 / (213) 947-6670
E-Mail Address: abruce@dmh.lacounty.gov / LWong@dmh.lacounty.gov

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PUBLIC PARTNERSHIP FOR WELLBEING (PP4W)
FUNDING SUMMARY
FISCAL YEAR 2019-20 THROUGH 2026-27
AMENDMENT NO. 23

DRAFT

FISCAL YEAR 2019-20						
FUNDING		General Clinical Education & Training	Training & Technical Services	Research & Evaluation	Technology & Innovation	FY Totals
DMH Mental Health Services Non-MC (CGF)		\$ 116,000				\$ 116,000
MHSA Workforce Education and Training (WET)		\$ 330,795	\$ 8,794,660		\$ 388,808	\$ 9,514,263
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 10,106,775			\$ 10,106,775
MHSA Recovery, Resiliency, & Reintegration Services Non-MC (CSS/RRR)			\$ 180,000	\$ 1,000,000		\$ 1,180,000
Department of Health Services (DHS)			\$ 50,000			\$ 50,000
Department of Public Health (DPH)			\$ 50,000			\$ 50,000
TOTAL		\$ 446,795	\$ 19,181,435	\$ 1,000,000	\$ 388,808	\$ 21,017,038

FISCAL YEAR 2020-21						
FUNDING	PP4W Director	Education & Training	Training & Technical Services	Research & Evaluation	Technology & Innovation	FY Totals
DMH Mental Health Services Non-MC (CGF)		\$ 116,000				\$ 116,000
MHSA Workforce Education and Training (WET)	\$ 143,256	\$ 363,137	\$ 6,029,024		\$ 1,224,625	\$ 7,760,042
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 9,115,246			\$ 9,115,246
MHSA Outpatient Care Services Non-MC (CSS/OCS)			\$ -	\$ 1,000,000		\$ 1,000,000
CARES ACT			\$ 179,341			\$ 179,341
Sales Tax Realignment			\$ 24,391			\$ 24,391
TOTAL	\$ 143,256	\$ 479,137	\$ 15,348,002	\$ 1,000,000	\$ 1,224,625	\$ 18,195,020

FISCAL YEAR 2021-22						
FUNDING	PP4W Director	Education & Training	Training & Technical Services	Research & Evaluation	Technology & Innovation	FY Totals
DMH Mental Health Services Non-MC (CGF)		\$ 116,000				\$ 116,000
MHSA Workforce Education and Training (WET)	\$ 143,256	\$ 363,137	\$ 5,911,471		\$ -	\$ 6,417,864
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 9,425,208	\$ 96,654		\$ 9,521,862
MHSA Outpatient Care Services Non-MC (CSS/OCS)			\$ 166,369	\$ -		\$ 166,369
			\$ -			\$ -
			\$ -			\$ -
TOTAL	\$ 143,256	\$ 479,137	\$ 15,503,048	\$ 96,654	\$ -	\$ 16,222,095

FISCAL YEAR 2022-23						
FUNDING	PP4W Director	Education & Training	Training & Technical Services	Research & Evaluation	Technology & Innovation	FY Totals
DMH Mental Health Services Non-MC (CGF)		\$ 116,000				\$ 116,000
MHSA Workforce Education and Training (WET)	\$ 143,256	\$ 363,137	\$ 5,158,880		\$ -	\$ 5,665,273
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 9,029,189	\$ 176,694		\$ 9,205,883
MHSA Outpatient Care Services Non-MC (CSS/OCS)			\$ 166,368	\$ -		\$ 166,368
			\$ -			\$ -
			\$ -			\$ -
TOTAL	\$ 143,256	\$ 479,137	\$ 14,354,437	\$ 176,694	\$ -	\$ 15,153,524

FISCAL YEAR 2023-24						
FUNDING	PP4W Director	Education & Training	Training & Technical Services	Research & Evaluation	Technology & Innovation	FY Totals
DMH Mental Health Services Non-MC (CGF)		\$ 116,000				\$ 116,000
MHSA Workforce Education and Training (WET)	\$ 143,256	\$ 404,755	\$ 5,776,507		\$ -	\$ 6,324,518
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 7,562,242			\$ 7,562,242
MHSA Outpatient Care Services Non-MC (CSS/OCS)			\$ -	\$ -		\$ -
			\$ -			\$ -
TOTAL	\$ 143,256	\$ 520,755	\$ 13,338,749	\$ -	\$ -	\$ 14,002,760

FISCAL YEAR 2024-25						
Funding	PP4W Director (Attach. 3)	Education & Training (Exhibit A.1, A.2)	Training & Technical Services (Exhibit B.2, B.3, B.4)	Research & Evaluation	Technology & Innovation	FY Totals
MHSA Workforce Education and Training (WET)	\$ 143,256	\$ 652,150	\$ 6,176,675			\$ 6,972,081
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 7,233,586			\$ 7,233,586
Dual Dx Set-Aside (SAMHSA)			\$ 310,500			\$ 310,500
Conservatorship Assessment Training (CAT-Program) (WET/TTA)			\$ 395,660			\$ 395,660
TOTAL	\$ 143,256	\$ 652,150	\$ 14,116,421			\$ 14,911,827

FISCAL YEAR 2025-26						
Funding	PP4W Director (Attach. 3)	Education & Training (Exhibit A.1, A.2)	Training & Technical Services (Exhibit B.2, B.3, B.4)	Research & Evaluation	Technology & Innovation	FY Totals
MHSA Workforce Education and Training (WET)	\$ 143,256	\$ 1,558,325	\$ 7,279,495			\$ 8,981,076
MHSA Prevention & Early Intervention Non-MC (PEI)			\$ 7,233,586			\$ 7,233,586
Dual Dx Set-Aside (SAMHSA)			\$ 77,760			\$ 77,760
TOTAL	\$ 143,256	\$ 1,558,325	\$ 14,590,841			\$ 16,292,422

FISCAL YEAR 2026-27 (ONE-YEAR EXTENSION)						
Funding	PP4W Director	Education & Training	Training & Technical Services	Research & Evaluation	Technology & Innovation	FY Totals
DMH 2011 Realignment Mental Health		\$ 2,531,867				\$ 2,531,867
BHSA Workforce Education and Training (WET)	\$ 143,256	\$ 2,895,422	\$ 7,533,586		\$ -	\$ 10,572,264
Innovation Program Improvements for Valued Outpatient Treatment (INN PIVOT)			\$ 3,988,149			\$ 3,988,149
			\$ -			\$ -
			\$ -			\$ -
TOTAL	\$ 143,256	\$ 5,427,289	\$ 11,521,735	\$ -	\$ -	\$ 17,092,280

OVERALL TCA \$ 132,886,966



DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

April 2, 2026

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM:

Lisa H. Wong, Psy.D.
Director

SUBJECT: **NOTICE OF INTENT TO EXTEND THE TERM OF THE PUBLIC PARTNERSHIP FOR WELLBEING CONTRACT WITH THE REGENTS OF THE UNIVERSITY OF CALIFORNIA ON BEHALF OF ITS LOS ANGELES CAMPUS ON A SOLE SOURCE BASIS**

In accordance with the Los Angeles County Board of Supervisors' (Board) Policy No. 5.100 (Sole Source Contracts and Amendments to Extend Contracts), the Department of Mental Health (DMH) is notifying your Board of our Department's intent to extend the existing Public Partnership for Wellbeing (PPFW) Contract with The Regents of the University of California on behalf of its Los Angeles Campus (The Regents) to continue provision of services.

DMH will request that your Board approve a sole source contract amendment to extend the term of the PPFW Contract with The Regents for one fiscal year effective July 1, 2026, through June 30, 2027. The total allocation for the extension period will be \$17,389,013, fully funded by Behavioral Health Services Act (BHSA) Workforce Education and Training-Training and Technical Assistance fund and 2011 Realignment - Mental Health.

JUSTIFICATION

DMH seeks to continue its partnership with The Regents (a public entity) through the PPFW Contract in order to receive the following ongoing services: 1) Education and Training; 2) Training and Technical Services; and 3) Innovation and Technology support.

The services support psychology post-doctoral clinicians, psychiatry residents, fellows, and other advanced trainees within DMH's directly operated clinics and/or contracted providers. Executing the amendment to extend the contract will prevent any lapse in services while DMH develops and negotiates a new sole-source contract. DMH will return to the Board at a later date requesting authority to execute the new contract.

Since inception of the contract with The Regents, a total of 253,190 PPFW trainings and courses have been completed by providers and community members across the County, including County employees from a number of departments, Mental Health, Health Services, Children and Family Services, and Public Health. In Fiscal Year 2024-25 providers and community members across the County completed 14,291 PPFW training courses, representing over 11,850 training hours. With over 64,000 active users in DMH and UCLA Wellbeing for LA Learning Center, DMH in collaboration with The Regents plan to expand the menu of training (in-person and live virtual) and resources that support and create professional, community, and peer training opportunities across the County's diverse ecosystems.

NOTIFICATION TIMELINE

Pursuant to Board Policy No. 5.100 (Sole Source Contracts and Amendments to Extend Contracts), DMH is required to notify your Board six months prior to expiration of an existing contract when the Department intends to execute an amendment to extend the contract term. Due to a number of factors, including the transition from the Mental Health Services Act to BHSA, for which the State has not yet released all implementing rules, and the time required to negotiate a new sole source contract with The Regents, DMH determined that a one-year extension is most suitable approach while we continue developing and negotiating the new sole-source contract; therefore, DMH is notifying the Board later than the required timeline. If requested by a Board Office or the Chief Executive Office, DMH will place this item on the Health and Mental Health Services Cluster Agenda.

DMH will submit the required notification to ensure compliance with the reporting requirements of Assembly Bill 339.

Unless otherwise instructed by your Board Office within two weeks of this notice, DMH will proceed with the action to extend the contract with The Regents for the services identified above and will present the Board letter for approval.

Each Supervisor
April 2, 2026
Page 3

If you have any questions or require additional information, please contact me at LWong@dmh.lacounty.gov or (213) 947-6670, or your staff may contact Stella Krikorian, Division Manager, Contracts Development and Administration Division, at SKrikorian@dmh.lacounty.gov or (213) 943-9146.

LHW:RH:KN
SK:CM:atm

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel



COUNTY OF LOS ANGELES BOARD OF SUPERVISORS POLICY 5.100 SOLE SOURCE CHECKLIST

Department Name: _____

- New Sole Source Contract
 - New Sole Source Contract for Replacement of Existing Services, or Amendments for Extension of Contracts for Existing Services
- Date Existing Contract First Approved: _____

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS AND AMENDMENTS TO EXTEND CONTRACTS Identify applicable justification and provide documentation for each checked item.
<input type="checkbox"/>	➤ Only one single source for the service exists.
<input type="checkbox"/>	➤ Compliance with applicable statutory and/or regulatory provisions.
<input type="checkbox"/>	➤ Compliance with State and/or federal programmatic requirements.
<input type="checkbox"/>	➤ Services provided by other public or County-related entities.
<input type="checkbox"/>	➤ Services are needed to address an emergent or related time-sensitive need.
<input type="checkbox"/>	➤ The service provider(s) is required under the provisions of a grant or regulatory requirement.
<input type="checkbox"/>	➤ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
<input type="checkbox"/>	➤ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
<input type="checkbox"/>	➤ Maintenance services and/or support services agreements are required on equipment and/or software, which must be serviced by the original manufacturer, software provider, or an authorized service representative.
<input type="checkbox"/>	➤ It is in the best economic interest of the County (e.g., significant costs and time to replace an existing system or infrastructure, administrative cost and time savings and excessive learning curve for a new service provider, etc.). In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Approved by:

_____ Chief Executive Office

_____ Date

DRAFT**BOARD LETTER/MEMO
CLUSTER FACT SHEET** Board Letter Board Memo Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input type="checkbox"/> All <input checked="" type="checkbox"/> 1 st <input checked="" type="checkbox"/> 2 nd <input checked="" type="checkbox"/> 3 rd <input checked="" type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Mental Health (DMH)	
SUBJECT	Approval to Amend Existing Legal Entity (LE) Contracts to Increase Their Maximum Contract Amounts (MCA) for Fiscal Year 2025-26 for the Continuous Provision and Expansion of Specialty Mental Health Services (SMHS)	
PROGRAM	DMH Various Programs – LE Contractors	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	If Yes, please explain why:	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No – Not Applicable If unsure whether a matter is subject to the Levine Act, email your packet to EOLevineAct@bos.lacounty.gov to avoid delays in scheduling your Board Letter.	
DEADLINES/ TIME CONSTRAINTS	6/9/26	
COST & FUNDING	Total cost: \$6,504,405 mil for LE contracts for FY 2025-26.	Funding source: Federal Financial Participation, State General Fund, and local revenues.
	TERMS (if applicable): FY 2025-26	
	Explanation: To increase the MCA for FY 2025-26 for the continuous expansion of SMHS.	
PURPOSE OF REQUEST	Amend existing LE contracts to increase MCA for the continued provision and expansion of SMHS due to the LE contracts reached their previously Board-approved 25 percent delegated authority for FY 2025-26.	
BACKGROUND (include internal/external issues that may exist including any related motions)	On May 7, 2024, your Board authorized the Director to extend the term of LE contracts. The same Board letter also delegated authority to DMH to amend the LE contracts to increase their MCAs up to 25 percent of their previously approved MCAs. As such, using the authority delegated, DMH amended these LE contracts up to the allowed 25 percent. Consequently, DMH is now returning to your Board for authority to further amend the LE contracts in order to increase their MCAs for FY 2025-26. The increase in funding will allow further provision of SMHS services including outreach, engagement, and outpatient referrals for additional clients/referrals received.	
EQUITY INDEX OR LENS WAS UTILIZED	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain how: Intervene Early and Emphasize Long Term Prevention. The SMHS to be provided through this request, seek to address and reduce the negative impact of mental illness of children, youth, adults, and families. The request will allow for the continued provision and expansion of mental health services to racially diverse underserved populations throughout the County, including prevention and early intervention services, with a goal of increasing positive outcomes for those being served, for their families and communities.	
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state which one(s) and explain how: Priority 1 Child Protection; Priority 3 Care First, Jails Last; Priority 4 Homeless Initiative; and Priority 8 Anti-Racism, Diversity, and Inclusion. These Priorities allows DMH to provide specialty mental health and support to vulnerable populations, including children and youth; families; residents experiencing mental health crisis; residents experiencing homelessness	

	and/or at risk of becoming homeless; and residents involved in/at-risk of becoming involved with the justice system.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: DMH: Stella Krikorian, Administrative Services Division Manager, (213) 943-9146, skrikorian@dmh.lacounty.gov DMH: Joo Yoon, Acting Deputy Director, (213) 943-8898, jyoon@dmh.lacounty.gov Senior Deputy County Counsel: Craig Kirkwood jr., (213) 974-7735, ckirkwood@counsel.lacounty.gov

Draft



DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

**APPROVAL TO AMEND EXISTING LEGAL ENTITY CONTRACTS TO INCREASE
THEIR MAXIMUM CONTRACT AMOUNTS FOR FISCAL YEAR 2025-26 FOR THE
CONTINUOUS PROVISION AND EXPANSION OF SPECIALTY MENTAL HEALTH
SERVICES
(SUPERVISORIAL DISTRICTS 1, 2, 3, and 4)
(3 VOTES)**

SUBJECT

Request approval to amend existing Department of Mental Health Legal Entity contracts to increase their Maximum Contract Amounts for Fiscal Year 2025-26 for the continuous provision and expansion of specialty mental health services.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or designee, to prepare, sign, and execute amendments, (similar to Attachment I), to existing Department of Mental Health (DMH) Legal Entity (LE) contracts, (as identified in Attachment II), to increase and reset the Maximum Contract Amounts (MCAs) for Fiscal Year (FY) 2025-26. The amendments will be effective upon Board approval; and the total aggregated increase is estimated to be \$6,504,405, fully funded by Federal Financial Participation (FFP), State General Fund (SGF), and local revenues.
2. Delegate authority to the Director, or designee, to prepare, sign, and execute future amendments to the LE contracts in Recommendation 1 to negotiate/revise contract language; add, delete, modify, negotiate, or replace the Statement(s) of Work and/or Service Exhibit(s) (SOW/SE), and Financial Provisions; reflect federal, State, and

County regulatory and/or policy changes; roll over federal and/or State grant funds from one fiscal year to the next fiscal year, or between line items, as appropriate; take contract actions related to provisions within the Financial Provisions (Exhibit A); revise the annual MCAs, provided that the County's total payment to each LE Contractor will not exceed an increase of more than 25 percent of the applicable annual MCA; all of which is contingent on sufficient funds being available as well as prior review and approval as to form by County Counsel with written notice to the Board and Chief Executive Office (CEO) are provided.

3. Delegate authority to the Director, or designee, to make non-material modifications to the LE contracts in Recommendation 1 through administrative amendments or change notices for the following and other similar reasons, as appropriate, which includes: changes to the contractors' business name and/or headquarter address; change, revise, add, or delete the contractors' provider site address(es), site number(s), site name(s), and/or services for an existing or new provider site; make technical corrections; revise County and Contractor Administration Exhibits; and/or shift funds between currently contracted funded programs, so long as such shift(s) will not cause an increase in the MCA.
4. Delegate authority to the Director, or designee, to terminate the contracts described in Recommendation 1 in accordance with the termination provisions of the contracts, including Termination for Convenience. The Director, or designee, will provide written notification to your Board and CEO of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Board approval of Recommendation 1 will allow DMH to amend the existing LE contracts identified in Attachment II to increase the MCAs to provide Specialty Mental Health Services (SMHS) and to support contractors' capacity in expanding services to new and existing beneficiaries. This approval is being sought because the referenced LE contracts have reached the limit of their previously Board-approved delegated authority for FY 2025-26. The increase in funding percentages is required due to the need to pay for services rendered as well as additional services to be provided during the rest of the fiscal year (i.e., entitlement funds).

Board approval of Recommendations 2 and 3 will allow DMH to amend the contracts in Recommendation 1 to negotiate/revise contract language; modify SOW/SE and Financial Provisions; roll over federal and/or State grant funds from one fiscal year to the next fiscal year or between line items; take contract actions related to provisions within the Financial Provisions (Exhibit A); and revise annual MCAs for the continuous provision and

expansion of SMHS and administrative corrections without interruption to clients in need of these services.

Board approval of Recommendation 4 will allow DMH to terminate the contracts in accordance with the contracts' termination provisions, including Termination for Convenience, in a timely manner, as necessary.

Implementation of Strategic Plan Goals

The recommended actions are consistent with the County's Strategic Plan North Star 1, Make Investments that Transform Lives, specifically Focus Area Goal A. Healthy Individuals and Families; and North Star 3. Realize Tomorrow's Government Today, specifically Focus Area Goal E. Data Driven Decision Making.

FISCAL IMPACT/FINANCING

The total aggregated increase for the LE contracts is estimated to be \$6,504,405 for FY 2025-26, fully funded by FFP, SGF, and local revenues.

Funding for future fiscal years will be requested through DMH's annual budget process.

There is no net County cost impact associated with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On May 7, 2024, your Board authorized the Director to extend the term of LE contracts, including contractors listed in Attachment II. The same Board letter also delegated authority to DMH to amend the LE contracts to increase their MCAs up to 25 percent of their previously approved MCAs. As such, using the authority delegated, DMH amended these LE contracts up to the allowed 25 percent. Consequently, DMH is now returning to your Board for authority to further amend the referenced LE contracts in order to increase their MCAs for FY 2025-26. The increase in funding will allow further provision of SMHS services including outreach, engagement, and outpatient referrals for additional clients/referrals received.

On May **TBD**, 2026, DMH requested an exemption to Board Policy No. 5.120 (Authority to Approve Increases to Board-Approved Contract Amounts) (Attachment III) from your Board for Medi-Cal funding in DMH's LE contracts.

The Honorable Board of Supervisors
June 9, 2026
Page 4

The amendment format (Attachment I) has been approved as to form by County Counsel. Attachment II lists the LE contractors, along with their headquarter addresses, Supervisorial District(s), Service Area(s), current MCAs, and funding source(s).

As mandated by your Board, the performance of all contractors is evaluated by DMH on an annual basis to ensure compliance with all contract terms and performance standards.

IMPACT ON CURRENT SERVICES OR PROJECTS

Board approval of the recommended actions will allow the LE contractors to provide ongoing SMHS services and allow DMH to make revisions/updates to the work provided by the contractors in a timely manner.

Respectfully submitted,

Lisa H. Wong, Psy.D.
Director

LHW:RH:KN:
SK:DO:atm

Attachments (3)

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

CONTRACT NO. MHxxxx

AMENDMENT NO. _____

THIS AMENDMENT is made and entered into this ___ day of June, 2026, by and between the COUNTY OF LOS ANGELES (hereafter “County”), and _____
_____ (hereafter “Contractor”).

WHEREAS reference is made to that certain document entitled “Department of Mental Health (DMH) Legal Entity Contract”, dated July 1, 2022, and further identified as County Contract No. MHxxxx, and all prior amendments (hereafter collectively “Contract”); and

WHEREAS, on June x, 2026, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute amendments to the Contract to revise the Maximum Contract Amount (MCA), and make other certain designated changes; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

WHEREAS, County and Contractor intend to amend the Contract to increase Specialized Foster Care (SFC) Wraparound Medi-Cal (MC) Funded Program funds; increase Post-Release Community Supervision–Community Reintegration (PCSR) Program Medi-Cal (MC) Funded Program funds; increase Mental Health Services Act (MHSA) Full Service Partnership (FSP) Invoice Funded Program funds; increase Mental Health Services Act (MHSA) Full Services Partnership (FSP) Medi-Cal (MC) Funded Program funds; increase Mental Health Services Act (MHSA) Outpatient Care Services

(OCS) Medi-Cal (MC) Funded Program funds; increase Mental Health Services Act (MHSA) Prevention & Early Intervention (PEI) Non-Medi-Cal (Non-MC) Funded Program funds; increase Mental Health Services Act (MHSA) Prevention & Early Intervention (PEI) Medi-Cal (MC) Funded Program funds; and make other hereinafter designated changes; and (update accordingly)

WHEREAS, as a result of the above change(s) in Funded Program funds the MCA will increase; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of the Contract, and consistent with the professional standard of care for these services.

NOW, THEREFORE, the County and Contractor agree as follows:

1. This amendment is hereby incorporated into the original Contract, and all its terms and conditions, including capitalized terms defined therein, will be given full force and effect as if fully set forth herein.
2. This amendment is effective upon execution for Fiscal Year (FY) 2025-26.
3. SFC Wraparound MC Funded Program funds are increased by \$_____, from \$_____ to \$_____.
4. PCSR Program MC Funded Program funds are increased by \$_____, from \$_____ to \$_____.
5. MHSA FSP Invoice Funded Program funds are increased by \$_____, from \$_____ to \$_____.
6. MHSA FSP MC Funded Program funds are increased by \$_____, from \$_____ to \$_____.
7. MHSA OCS MC Funded Program funds are increased by \$_____, from \$_____.

- to \$_____.
8. MHSA PEI Non-MC Funded Program funds are increased by \$_____, from \$_____ to \$_____.
 9. MHSA PEI MC Funded Program funds are increased by \$_____, from \$_____ to \$_____. (update accordingly)
 10. For FY 2025-26, the MCA is increased by \$_____, from \$_____ to \$_____.
 11. Exhibit A (FINANCIAL PROVISIONS), Paragraph C (REIMBURSEMENT IF CONTRACT IS AUTOMATICALLY RENEWED AND EXTENDED), subparagraph (4) is deleted in its entirety and replaced as follows:

“(4) Reimbursement for Second Extension Period: The MCA for the second extension of the Contract as described in Paragraph 4 (TERM) of the Contract shall not exceed _____ DOLLARS (\$_____) and shall consist of Funded Programs as shown in Exhibit B – ____.”
 12. Financial Summary (Exhibit B – __) for FY 2025-26 is deleted in its entirety and replaced with Financial Summary (Exhibit B – __) for FY 2025-26, attached hereto and incorporated by reference. All references in the Contract to “Financial Summary (Exhibit B – __) for FY 2025-26”, shall be deemed amended to state “Financial Summary (Exhibit B – __) for FY 2025-26.”
 13. Contractor shall provide services in accordance with Contractor’s FY 2025-26 Service Delivery Plan for the Contract, and any addenda thereto approved in writing by the County’s Director of Mental Health, or designee.
 14. Except as provided in this amendment, all other terms and conditions of the Contract will remain in full force and effect.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this amendment to be subscribed by County's Director of Mental Health, or designee, and Contractor has caused this amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
LISA H. WONG, Psy.D., Director
County of Los Angeles
Department of Mental Health

CONTRACTOR

By _____

Name _____

Title _____

(AFFIX CORPORATE SEAL HERE)

TEMPLATE APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: CRAIG KIRKWOOD JR.
Deputy County Counsel

Legal Entity Contracts - Fiscal Year 2025 - 26

	Legal Entity Contractor Name/DBA (if applicable)	Headquarters Address	Service Provider Supervisorial District(s)	Service Provider Service Area(s)	FY 25-26 Current MCA	FY 25-26 Total Increase	FY 25-26 Revised MCA
1	Eggleston Youth Centers, Inc.	256 W. Badillo Street, Covina, CA 91723	1	3	\$7,724,109	\$502,511	\$8,226,620
2	HealthRIGHT 360	1563 Mission Street, San Francisco, CA 94103	Out of County	Out of county	\$11,528,386	\$1,060,323	\$12,588,709
3	Korean American Family Services, Inc.	3727 W. 6th Street, Ste. 320, Los Angeles, CA 90020	3	4	\$704,676	\$15,065	\$719,741
4	Olive Crest	2130 E. 4th St #200, Santa Ana, CA 92705	Out of County	Out of county	\$5,482,739	\$590,138	\$6,072,877
5	One In Long Beach, Inc.	2017 E. 4th Street, Long Beach, CA 90814-1011	4	8	\$370,386	\$60,000	\$430,386
6	Stirling Academy, Inc.	6931 Van Nuys Blvd., Suite 102, Van Nuys, CA 91405	2	2	\$3,338,503	\$308,300	\$3,646,803
7	Telecare Corporation	1080 Marina Village Parkway, Ste. 100, Alameda, CA 94501-1078	Out of County	Out of county	\$28,705,269	\$1,810,961	\$30,516,230
8	The Guidance Center	1301 Pine Avenue, Long Beach, CA 90813	4	8	\$21,564,464	\$2,157,107	\$23,721,571
					\$79,418,532	\$6,504,405	



DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

Attachment III

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

May XX, 2026

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Lisa H. Wong, Psy.D.
Director

SUBJECT: **NOTICE OF INTENT TO REQUEST DELEGATED AUTHORITY FOR
A PERCENTAGE INCREASE EXCEEDING TEN PERCENT OF THE
MAXIMUM CONTRACT AMOUNT FOR THE DEPARTMENT OF MENTAL
HEALTH'S LEGAL ENTITY CONTRACTS**

In accordance with the Los Angeles County Board of Supervisors' (Board) Policy No. 5.120 (Authority To Approve Increases To Board-Approved Contract Amounts), the Department of Mental Health (DMH) is notifying your Board of our Department's intent to request delegated authority for a percentage increase exceeding ten percent of the Maximum Contract Amount (MCA) for certain existing Legal Entity (LE) contracts. DMH will request delegated authority for a 25 percent increase of their MCAs for the existing LE contracts for Fiscal Year (FY) 2025-26.

JUSTIFICATION

DMH will present your Board a letter for approval to amend the LE contracts for FY 2025-26 to increase their MCAs as the contractors have reached their previously Board-approved 25 percent delegated authority. The total aggregated increase is estimated to be \$6,504,405, fully funded by Federal Financial Participation, State General Fund, and local revenues.

Each Supervisor
May XX, 2026
Page 2

The authority to increase the percentage exceeding ten percent allows DMH to amend the LE contracts in a timely manner for the provision and expansion of specialty mental health services without interruption to clients who need these services.

NOTIFICATION TIMELINE

Board Policy No. 5.120 requires departments to provide written notice to your Board, with a copy to the Chief Executive Office, at least two weeks prior to the Board Meeting at which the request to exceed ten percent of the MCA will be presented. In compliance with this policy, DMH is notifying your Board of our intent to request delegated authority for up to 25 percent of the MCA through a Board letter to be presented on June 9, 2026.

If you have any questions or require additional information, please contact me at LWong@dmh.lacounty.gov or (213) 947-6670, or your staff may contact Stella Krikorian, Division Manager, Contracts Development and Administration Division, at SKrikorian@dmh.lacounty.gov or (213) 943-9146.

LHW:RH:KN
SK:DO:atm

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

**BOARD LETTER/MEMO
CLUSTER FACT SHEET**

Board Letter

Board Memo

Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input checked="" type="checkbox"/> All <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Department of Public Health	
SUBJECT	RECOMMENDATION TO TERMINATE THE DECLARED LOCAL HEALTH EMERGENCY FOR THE JANUARY 2025 CRITICAL FIRE EVENTS	
PROGRAM	Executive Office Services	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	If Yes, please explain why:	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Not Applicable	
	If unsure whether a matter is subject to the Levine Act, email your packet to EOLevineAct@bos.lacounty.gov to avoid delays in scheduling your Board Letter.	
DEADLINES/ TIME CONSTRAINTS		
COST & FUNDING	Total cost: \$	Funding source:
	TERMS (if applicable):	
	Explanation: There was no fiscal impact related to the continuance of this local health emergency, but the proclamation of local health emergency could allow the County to seek recovery of eligible costs from the Federal Emergency Management Agency and State of California. The County will incur costs associated with the response to and recovery from the local health emergency.	
PURPOSE OF REQUEST	The local health emergency declared by the local health officer on January 10, 2025, was ratified by the Board on January 14, 2025, and initially extended on February 11, 2025, and continued thereafter, must be reviewed by the Board to determine the need for the local health emergency to remain in effect at least once every 30 days, until it is terminated; and (2) proclaim the local health emergency terminated at the earliest possible date that conditions warrant the termination.	
	Conditions have shifted from an acute, immediate public health threat driven by widespread risks from active wildfires and fire debris, including hazardous household materials and remaining fire debris, to a more controlled state following completion of cleanup within burned properties.	

	Based on a review of the above listed factors, Public Health is recommending that the Board now find that it is warranted to terminate the January 2025 Windstorm and Critical Fire Events local health emergency, as proclaimed by the Public Health Officer on January 10, 2025.
BACKGROUND (include internal/external issues that may exist including any related motions)	<p>The January 2025 Windstorm and Critical Fire Events are an ongoing local health emergency in Los Angeles County, which has required an ongoing response to several destructive and wind-driven fires, especially the Palisades and Eaton Fires. These fires have burned thousands of residences and structures and resulted in massive amounts of post-fire health hazards in the form of burned hazardous materials and hazardous ash, soot and fire debris remaining in the burn and surrounding areas. The recovery response to these catastrophic fire events requires the ongoing need for federal, State and local emergency response and recovery operations to implement and complete a large scale urban wildfire debris removal and disposal and evaluate related human health risks.</p> <p><u>Board Motion</u> On January 14, 2025, via motion, the Board ratified the County Health Officer's Declaration of Local Health Emergency made on January 10, 2025, for the January 2025 Windstorm and Critical Fire Events, in the County of Los Angeles. The Proclamation of Local Health Emergency shall remain in effect until its termination is proclaimed by the Board.</p>
EQUITY INDEX OR LENS WAS UTILIZED	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: <ul style="list-style-type: none"> • Joshua Bobrowsky Director of Government Affairs, Public Health jbobrowsky@ph.lacounty.gov • Blaine D. McPhillips Senior Deputy County Counsel Health Services Division bmcpillips@counsel.lacounty.gov



DRAFT

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

ANISH P. MAHAJAN, M.D., M.S., M.P.H.
Chief Deputy Director

313 North Figueroa Street, Suite 806
Los Angeles, CA 90012
TEL (213) 288-8117 • FAX (213) 975-1273

www.publichealth.lacounty.gov

BOARD OF SUPERVISORS

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Lindsey P. Horvath
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

June 09, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

**RECOMMENDATION TO TERMINATE THE DECLARED LOCAL HEALTH
EMERGENCY FOR THE JANUARY 2025 CRITICAL FIRE EVENTS
(ALL AFFECTED) (3 VOTES)**

SUBJECT

The Department of Public Health (Public Health) is recommending that the Board of Supervisors (Board) terminate the local health emergency declared on January 10, 2025, in response to the January 2025 Windstorm and Critical Fire Events impacting Los Angeles County (County).

IT IS RECOMMENDED THAT THE BOARD:

1. Adopt and approve the attached Resolution to Terminate a Local Health Emergency, which was proclaimed as a result of the January 2025 Windstorm and Critical Fire Events in the County of Los Angeles.
2. Direct the Chief Executive Officer Office of Emergency Management (CEO-OEM) to forward a copy of the Resolution to Terminate A Local Healthy Emergency to the Director of the California Governor’s Office of Emergency Services.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

After a local health emergency has been proclaimed by the local health officer, State law requires that the Board: (1) review the need for the proclaimed local health emergency to

remain in effect at least once every 30 days, until it is terminated; and (2) proclaim the local health emergency terminated at the earliest possible date that conditions warrant. Public Health, in conjunction with the involved County Departments, has reviewed the need for the proclaimed local health emergency referenced below to remain in effect, and/or whether it is now warranted for the local health emergency to be terminated. This review included considerations of the extent to which the specified conditions for the proclaimed local health emergency (i.e., whether a hazardous waste release or escape is an immediate threat to the public health or whether there is an imminent and proximate threat of the introduction of any chemical agent, noncommunicable biologic agent, toxin, or radioactive agent) are still existing; the ongoing need for emergency response and recovery operations; the ongoing need for federal and/or State financial assistance; and the extent to which departments continue to engage in essential emergency-related activities that are dependent on the local health emergency remaining in effect.

Conditions have shifted from an acute, immediate public health threat driven by widespread risks from active wildfires and fire debris, including hazardous household materials addressed in Phase 1 and remaining fire debris addressed in Phase 2, to a more controlled state following completion of Phase 2 cleanup within burned properties.

Based on a review of the above listed factors, Public Health is recommending that the Board now find that it is warranted to terminate the January 2025 Windstorm and Critical Fire Events local health emergency, as proclaimed by the Public Health Officer on January 10, 2025.

Implementation of Strategic Plan Goals

These recommendations support the County Strategic Plan: North Star 2 – Foster Vibrant and Resilient Communities, Focus Area A – Public Health, Strategy i - Population Based Health.

FISCAL IMPACT/FINANCING

There is no fiscal impact on current services.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

California Health and Safety Code Section 101080 and Chapter 2.68 of the Los Angeles County Code requires the Board to review the need for a proclaimed local health emergency to remain in effect at least once every 30 days, until it is terminated. California Health and Safety Code Section 101080 requires the Board to terminate a proclaimed local health emergency at the earliest possible date that conditions warrant.

ENVIRONMENTAL DOCUMENTATION

This action is not subject to the California Environmental Quality Act (CEQA) because it is excluded from the definition of project under section 15378(b)(5) of the State CEQA Guidelines.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

There is no impact on current services.

The impacts of the fires that burned throughout Los Angeles County in January 2025 will be long-lasting. Thousands of homes and other structures have been lost.

For a comprehensive list of information related to wildfires response services being provided by the County of Los Angeles, visit <https://recovery.lacounty.gov/road/>.

Concerned residents are advised to continue to follow precautions and guidance to protect their health and well-being after a fire, available on Public Health's website at <http://publichealth.lacounty.gov/media/Wildfire/>.

CONCLUSION

Upon approval by the Board, an adopted, stamped copy should be returned to CEO-OEM. A copy of the Resolution to Terminate A Local Health Emergency will be forwarded to the Governor's Office of Emergency Services for their records.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:db
08565

Enclosure

c: Chief Executive Officer
County Counsel
Executive Office, Board of Supervisors
Public Works
CEO Office of Emergency Management

**RESOLUTION BY THE COUNTY OF LOS ANGELES BOARD OF SUPERVISORS TO
TERMINATE THE PROCLAMATION OF A LOCAL HEALTH EMERGENCY FOR THE JANUARY
2025 WINDSTORM AND CRITICAL FIRE EVENTS**

WHEREAS, on January 10, 2025, the County Public Health Officer, Dr. Muntu Davis, declared a local health emergency for the January 2025 Windstorm and Critical Fire Events, pursuant to Health and Safety Code Sections 101040, 101080, and 120175, which was also ratified by the Board of Supervisors (Board) on January 14, 2026, due to the existence of an immediate threat to the public health in the County of Los Angeles, as a result of the potential for widespread toxic exposures, debris from fire damage including damaged building materials, contamination with heavy metals, debris and ash from residential structures, and hazardous household substances that may have burned or released in the fire; and

WHEREAS, Health and Safety Code Section 101080 provides that after the Board ratifies a declared local health emergency the Board shall review, at least every 30 days, the need for continuing the local health emergency and shall proclaim the termination of the local health emergency at the earliest possible date that conditions warrant the termination; and

WHEREAS, with respect to the above local health emergency initially proclaimed by the Health Officer and ratified by the Board on January 14, 2025, and thereafter extended, the conditions relating thereto are such that, effective June 9, 2026, it is warranted that the declared local health emergency for the January 2025 Windstorm and Critical Fire Events, be terminated; and

NOW, THEREFORE, BE IT RESOLVED AND ORDERED by the Board of Supervisors of the County of Los Angeles that, effective June 9, 2026, the declared local health emergency for the January 2025 Windstorm and Critical Fire Events is terminated.

IT IS FURTHER ORDERED that, effective June 9, 2026, any and all emergency orders issued by the Health Officer and ratified by the Board, pursuant to Health and Safety Code Sections 101040 and 101080 relating to the declared local health emergency for the January 2025 Windstorm and Critical Fire Events are terminated and no longer in effect.

IT IS FURTHER ORDERED that, on or after June 9, 2026, a copy of this Resolution be forwarded to the Director of the California Governor's Office of Emergency Services.

The foregoing resolution was on the 9th day of June 2026, adopted by the Board of Supervisors of the County of Los Angeles and ex officio the governing body of all other special assessment and taxing districts, agencies and authorities for which said Board so acts.

**BOARD LETTER/MEMO
CLUSTER FACT SHEET**

DRAFT

Board Letter

Board Memo

Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input checked="" type="checkbox"/> All <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Department of Mental Health	
SUBJECT	Adopt the Department of Mental Health's Three Year Integrated Plan for Behavioral Health Services and Outcomes	
PROGRAM	Behavioral Health Services Act	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain why:	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Not Applicable If unsure whether a matter is subject to the Levine Act, email your packet to EOLevineAct@bos.lacounty.gov to avoid delays in scheduling your Board Letter.	
DEADLINES/ TIME CONSTRAINTS	6/9/2026	
COST & FUNDING	Total cost:	Funding source:
	none	N/A
	TERMS (if applicable): N/A	
	Explanation: N/A	
PURPOSE OF REQUEST	This Board letter will allow the adoption of the Department of Mental Health's (DMH) Three Year Integrated Plan. In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act and fund needed behavioral health facility infrastructure, thus transitioning to the Behavioral Health Services Act (BHSA). BHSA requires that counties develop and submit a three-year IP for Behavioral Health Services and Outcomes and Annual Updates consistent with BHSA Policy Manual, and any other applicable DHCS guidance (W&I §§ 5963 et seq.).	
BACKGROUND (include internal/external issues that may exist including any related motions)	Senate Bill (SB) 326 requires all county Behavioral Health Departments, which in Los Angeles County consists of the Departments of Mental Health and Public Health, to submit an IP outlining intended use of funds and a budget for behavioral health programs administered, beginning with FYs 2026-27 through 2028-29. The public hearing requirements referenced in W&I §5963.03 have been fulfilled and are recorded in the IP. The Director of DMH and the Director of DPH have both signed the Behavioral Health Director Certification form attesting that the County of Los Angeles has complied with all applicable statutes, regulations, and guidelines and adheres to fiscal accountability and stakeholder participation requirements. The CEO has signed the County Administrator Certification form attesting to the use of BHSA funding. Both forms are included in the BHSA IP.	
EQUITY INDEX OR LENS WAS UTILIZED	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain how:	
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please state which one(s) and explain how:	
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Kalene Gilbert, Program Manager IV, 213.943.8223, KGilbert@dmh.lacounty.gov William Birnie, Senior Deputy Counsel, 213.972.5717, WBirnie@counsel.lacounty.gov	



DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**ADOPT THE DEPARTMENT OF MENTAL HEALTH'S
THREE YEAR INTEGRATED PLAN FOR BEHAVIORIAL HEALTH SERVICES AND
OUTCOMES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

SUBJECT

Request adoption of the Department of Mental Health's Three-Year Integrated Plan for Behavioral Health Services and Outcomes for Fiscal Years 2026-27 through 2028-29.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Adopt the Department of Mental Health's (DMH) Three-Year Integrated Plan (IP) for Behavioral Health Services and Outcomes for Fiscal Years (FYs) 2026-27 through 2028-29.
2. Delegate authority to the Director, or designee, to amend the IP in Recommendation 1 to reflect administrative revisions, statutory and/or policy changes as requested by the State.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act and fund needed behavioral health facility infrastructure, thus transitioning to the Behavioral Health Services Act (BHSA). The primary goals of the BHSA are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California. BHSA requires that counties develop and submit a three-

year IP for Behavioral Health Services and Outcomes and Annual Updates consistent with BHSA Policy Manual, and any other applicable DHCS guidance, Welfare and Institutions (W&I) Code §§ 5963, et seq.

In accordance with W&I Code § 5963.02, DMH in collaboration with Department of Public Health (DPH), will prepare and submit the IP to the County Board of Supervisors for adoption. Board approval of the recommended action will allow DMH to submit the IP to the State of California's Department of Health Care Services and the Behavioral Health Services Oversight and Accountability Commission per W&I Code § 5963.02.

W&I Code § 5963.03 requires the County's DMH to post the draft IP, for at least 30 days, for stakeholders and the public to review and provide comments. As such, DMH posted the draft IP on its website on February 11, 2026. At the close of the 30-day public review period, DMH and the Behavioral Health Commission convened a Public Hearing on April 9, 2026, where DMH presented the IP to stakeholders and the public.

The IP has been certified by DMH's Director, the Director of DPH Substance Abuse Prevention and Control Bureau, and the Chief Executive Officer (CEO), to meet specified BHSA requirements in accordance with W&I Code § 5963.02.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County's Strategic Plan North Star 1 (Make Investments that Transform Lives), via Focus Area Goal A. (Healthy Individuals and Families) and County's Strategic Plan North Star 3 (Realize Tomorrow's Government Today), via Goal A. Communication and Public Access).

FISCAL IMPACT/FINANCING

There is no net County cost impact associated with the recommended action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Senate Bill (SB) 326 requires all county behavioral health departments, which in Los Angeles County consists of the Departments of Mental Health and Public Health, to submit an IP outlining intended use of funds and a budget for behavioral health programs administered, beginning with FYs 2026-27 through 2028-29.

Each county mental health program must prepare an IP which is to be adopted by the Board and submitted to the Behavioral Health Services Oversight and Accountability Commission and the State Department of Health Care Services.

The public hearing requirements referenced in W&I Code § 5963.03 have been fulfilled and are recorded in the IP. The Director of DMH and the Director of DPH have both signed the Behavioral Health Director Certification form attesting that the County of Los Angeles has complied with all applicable statutes, regulations, and guidelines and adheres to fiscal accountability and stakeholder participation requirements. The CEO has signed the County Administrator Certification form attesting to the use of BHSA funding. Both forms are included in the BHSA IP. As a final condition for submitting the IP, the Board will need to sign the attached Certification (Attachment II) indicating that the Board has reviewed and approved the IP and attests that the County will meet the realignment obligation pursuant to W&I Code § 14197.

IMPACT ON CURRENT SERVICES

Board adoption of the IP will ensure compliance with SB 326 requirements and ensure clients have timely access to appropriate services.

Respectfully submitted,

LISA H. WONG, Psy D.
Director

LHW:RH:KN:RR:SK:ZW:atm

Attachments

- c: Executive Office, Board of Supervisors
- Chief Executive Office
- County Counsel
- Chairperson, Behavioral Health Commission

LOS ANGELES COUNTY: BEHAVIORAL HEALTH SERVICES ACT INTEGRATED PLAN RESPONSES

**Submitted to the State Department of Health Care
Services: January 2026**

**Posted for Public Review:
February 11, 2026-March 13, 2026**

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Introduction

The Behavioral Health Services Act (BHSA) ([Senate Bill \(SB\) 326, Chapter 90, Statutes of 2023](#)) requires all county Behavioral Health Departments to submit a [three-year Integrated Plan for Behavioral Health Services and Outcomes](#) outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029).

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General Information

1. **County, City, Joint Powers, or Joint Submission**
County
2. **Entity Name (county, city, joint powers, or other)**
Los Angeles
3. **Behavioral Health Agency Name**
Los Angeles County Department of Mental Health
Substance Abuse Prevention and Control, Los Angeles County Department of Public Health
4. **Behavioral Health Agency Mailing Address**
Mental Health: 510 S. Vermont Avenue, Los Angeles, CA 90020
SUD: 313 N. Figueroa St., Los Angeles, CA 90012
5. **Primary Mental Health Contact**
 - a. **Name:** Lisa Wong, PsyD
 - b. **Email:** lwong@dmh.lacounty.gov
 - c. **Phone:** (213) 947-6770
6. **Secondary Mental Health Contact**
 - a. **Name:** Kalene Gilbert, LCSW
 - b. **Email:** kgilbert@dmh.lacounty.gov
 - c. **Phone:** (213) 943-8233
7. **Primary Substance Use Disorder Contact**
 - a. **Name:** Gary Tsai, MD
 - b. **Email:** gtsai@ph.lacounty.gov
 - c. **Phone:** (626) 299-4595
8. **Secondary Substance Use Disorder Contact**
 - a. **Name:** Michelle Gibson, MPH
 - b. **Email:** migibson@ph.lacounty.gov
 - c. **Phone:** (626) 299-4595
9. **Primary Housing Interventions Contact**
 - a. **Name:** Maria Funk, PhD
 - b. **Email:** mfunk@dmh.lacounty.gov
 - c. **Phone:** (213) 943-8465
10. **Compliance Officer for Specialty Mental Health Services (SMHS)**
 - a. **Name:** Venezia Mojarro
 - b. **Email:** vmojarro@dmh.lacounty.gov
11. **Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services**
 - a. **Name:** Setareh Yavari
 - b. **Email:** syavari@ph.lacounty.gov
12. **Behavioral Health Services Act (BHSA) Coordinator**

Name	Email Address
Kalene Gilbert	Kgilbert@dmh.lacounty.gov

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

Name	Email Address
Stephanie Chor	schor@dmh.lacounty.gov
Gary Tsai, MD	gtsai@ph.lacounty.gov

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

Name	Email Address
Jennifer Hallman, LCSW, MPA	jhallman@dmh.lacounty.gov
Brian Hurley, MD	bhurley@ph.lacounty.gov

15. **Medical Director**

Name	Email Address
Curley Bonds II, MD	cbonds@dmh.lacounty.gov
Brian Hurley, MD	bhurley@ph.lacounty.gov

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County Behavioral Health System Overview

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

Populations Served by County Behavioral Health System

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

Children and Youth

1. In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row.

Counts may be duplicated as individuals may be included in more than one category.

Table 1. Number of Children and Youth Served

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	85,700
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	162
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	2,092
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	971
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	115
Were chronically homeless or experiencing homelessness or at risk of homelessness	6,277 ¹
Were in the juvenile justice system	526 ²
Have reentered the community from a youth correctional facility	2,340 ³
Were served by the Mental Health Plan and had an open child welfare case	17,562
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	110

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	4,158 ⁴

¹Data Source: LACDMH used the population data for persons in households with at least one adult and one child, children under age 18 and persons in household with only children from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report. These figures may not include clients served by LACDMH

²Data Source: California Board of State and Community Corrections (BSCC) Juvenile Detention Profile Survey Dashboard County Probation Department data: Average Daily Population for 2025. These figures may not include clients served by LACDMH.

³Data Source: California Board of State and Community Corrections (BSCC) Jail Population Survey Dashboard. Average number of youth discharged per month in 2024 was 195.

⁴Fiscal Year 2024-25

Adults and Older Adults

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

Table 2. Adults and Older Adults Served

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	5,082
Received Medi-Cal SMHS	117,900
Received DMC or DMC-ODS services	29,800
Received MH and SUD services from the MHP and DMC county or DMC- ODS plan	29,591
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	29,076 ¹
Experienced unsheltered homelessness	16,374 ²
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	7,575 ³
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	337 ⁴ This number represents SAPC only, DMH does not collect this data
Were in the justice system (on parole or probation and not currently incarcerated)	11,774 ⁵
Were incarcerated (including state prison and jail)	58,349 ⁶
Reentered the community from state prison or county jail	31,980 ⁷
Received acute psychiatric services	19,167 ⁸

¹Data Source: LACDMH used the population data for severely mentally ill (SMI) from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report: 15,666. This figure was combined with SAPC: 13,410. These figures may not include clients served by LACDMH.

²Data Source: LACDMH used the population data for severely mentally ill (SMI) from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report: 11,263. This figure was combined with SAPC: 5,111. These figures may not include clients served by LACDMH.

³Data Source: LACDMH used the population data for severely mentally ill (SMI) from the HUD 2024 Continuum of Care Homelessness Assistance Programs Homeless Populations and Subpopulations Report: 4,403. This figure was combined with SAPC: 3,532. These figures may not include clients served by LACDMH.

⁴The number reported is only for SAPC. LACDMH does not have any numbers to report.

⁵Data Source: LACDMH clients included are those served in AB109, the Community Reintegration Program and those with a justice involved focal population in Full Service Partnership program. This count represents an undercount, given that many justice-involved clients receive services through additional outpatient programs. 5,877

⁶Data Source: California Board of State and Community Corrections (BSCC) Jail Population Survey Dashboard: Calendar Year 2024

⁷Data Source: Data pulled 12/18/2025 from the Los Angeles County: Chief Information Office: Justice Data Center: [Released Person](#)

[Dashboard Subtracted](#). Number derived using the average number released to custody (27,612) subtracted from the average number of inmates released (59,592). These figures may not include clients served by LACDMH.SAPC reported 182. Time frame: January 2025-October 2025.

⁸Fiscal Year 2024-25

2. **Input the number of persons in designated and approved facilities who were**
 - a. **Admitted or detained for 72-hour evaluation and treatment rate:** 50,507
 - b. **Admitted for 14-day periods of intensive treatment:** 32,492
 - c. **Admitted for 30-day periods of intensive treatment:** 3,317
 - d. **Admitted for 180-day post certification intensive treatment:** N/A
3. **Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs:** 1,814
4. **Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs):** N/A
5. **Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?** No
6. **Please describe the local data used during the planning process:**

The local data included Medi-Cal client counts by age, race and ethnicity to inform planning and help identify disparities.
7. **If desired, provide documentation on the local data used during the planning process:** N/A

Local CARE Act Implementation

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

The integrated components within the 3-year plan that will serve CARE participants will include the following:

- Full-Service Partnership (FSP) (ACT, and/or ICM), Outpatient Services, other intensive field-based services and/or Peer Support Services.

The CARE Court Program may be layered upon any of the above integrated plan (IP Components) to provide appropriate and comprehensive mental health services. These components will support each individual's unique needs by providing tailored and comprehensive mental health services to support recovery and goal attainment. The services overall are field based and intensive in nature and work across both Court, Behavioral Health, and other system partners.

The county will ensure CARE Court participants receive priority access and specialized coordination within the broader behavioral health continuum, including housing by maintaining a specialized CARE Court Program which can both provide and coordinate direct services to this specialized and unique population. This enables CARE Court participants to be prioritized and not experience any substantial delays in receiving comprehensive field-based mental health services. As it relates to housing, the CARE Court Team regularly coordinates with the DMH Housing division to ensure that CARE

Court clients experience seamless and expedited pathways to the full continuum of housing resources.

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

CARE referral pathways are integrated into existing referral and service pathways within the county Behavioral Health System by leveraging the department wide Service Requests Tracking System (SRTS) and Universal Entry. The DMH 24/7 Access Help Line also serves as an important avenue that funnels CARE Court referrals and inquiries to the CARE Court team. These pathways allow for “no wrong door” access to DMH services while at the same time promoting the tracking and disposition of each request for services.

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

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 includes the following:

- Referral review of potential CARE Court clients by clinical staff which may include clinical interview, review of pertinent records, and/or information from collaterals.
- Evaluation of client’s readiness to accept appropriate and needed mental health services without court oversight
- Consultation and linkage to an appropriate mental health service that meets the client’s needs

Individuals who are redirected from the CARE Court program are referred to other available mental health services that will meet and address their specific needs. Referrals received from the community may be transferred to an appropriate provider via SRTS where a disposition is tracked and required. Referrals received from mental health providers that are not appropriate for CARE Court will receive consultation and navigation support to promote effective linkage to the needed mental health services. These dispositions are tracked through the department wide SRTS and universal entry systems.

Successful connection to mental health services will be documented in the SRTS and/or Universal Entry tracking systems.

County Behavioral Health Technical Infrastructure

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

1. **Does the county's behavioral health system use an Electronic Health Record (EHR)?**
Yes
 - a. **The County uses the following EHR:** Netsmart
2. **Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)?** Yes
 - a. **The County participates in the following QHIO:** Los Angeles Network for Enhanced Services (LANES)

Application Programming Interface Information

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

1. **Please provide the link to the county's API endpoint on the county behavioral health plan's website:**
 - <https://hidex.dmh.lacounty.gov/provider/metadata>
 - Patient Access API: <https://pax.sapc.ph.lacounty.gov/swagger/index.html>
 - Provider Directory API: <https://pdex.sapc.ph.lacounty.gov/swagger/index.html>
2. **Does the county wish to disclose any implementation challenges or concerns with these requirements?** No
3. **Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs [23-056](#), [23-057](#), and [24-016](#). Does the county wish to disclose any implementation challenges or concerns with these requirements?** No

County Behavioral Health System Service Delivery Landscape

For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

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

1. **Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?** Yes
 - a. The county behavioral health system plans to provide the following services under the PATH grant:
 - Alcohol or Drug Treatment Services
 - Case Management Services
 - Community Mental Health Services
 - Habilitation and Rehabilitation Services
 - Outreach Services
 - Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
 - Screening and Diagnostic Treatment Services
 - Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services
2. **The County's referrals for Primary Health Care, Job Training, Educational Services, and Housing Services are the following:**
 - Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations
 - Improving the Coordination of Housing Services
 - One-time Rental Payments to Prevent Eviction
 - Planning of Housing
 - Security Deposits
 - Technical Assistance in Applying for Housing
3. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?** No

Community Mental Health Services Block Grant (MHBG)

1. **Will the county behavioral health system participate in any [MHBG](#) set-asides during the Integrated Plan period?** Yes
 - a. **The county behavioral health system plans to participate in the following under the MHBG:**
 - Children's System of Care Set-Aside
 - Discretionary/Base Allocation
 - Dual Diagnosis Set-Aside
 - First Episode Psychosis Set-Aside
 - Integrated Services Agency Set-Aside

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

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

1. **Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period? Yes**
 - a. **The county behavioral health system participates in the following set-asides under SUBG:**
 - Adolescent/Youth Set-Aside
 - Discretionary
 - Perinatal Set-Aside
 - Primary Prevention Set-Aside
2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? No**

Opioid Settlement Funds (OSF)

1. **Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period? Yes**
 - a. **The county behavioral health system participates in the following set asides under OSF Exhibit E:**
 - Address The Needs of Criminal Justice-Involved Persons
 - Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
 - Connect People Who Need Help to The Help They Need (Connections to Care)
 - First Responders
 - Leadership, Planning, and Coordination
 - Prevent Misuse of Opioids
 - Prevent Overdose Deaths and Other Harms (Harm Reduction)
 - Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
 - Support People in Treatment and Recovery
 - Treat Opioid Use Disorder (OUD)
 - Training
2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? No**

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).

- 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
1. **In addition, BMA funds may be used for the specific services identified in the list below. Services that are funded with BMA funds include: N/A**
 2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? No**

Public Safety Realignment (2011 Realignment)

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

- Drug Courts
 - Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
 - Regular and Perinatal Drug Medi-Cal Services
 - Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
 - Regular and Perinatal Non-Drug Medi-Cal Services
1. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? No**

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Residential Treatment Services
- 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 for individuals under the age of 21
- High Fidelity Wraparound for individuals under the age of 21
- Intensive Care Coordination for individuals under the age of 21
- Intensive Home-based Services for individuals under the age of 21
- Multisystemic Therapy for individuals under the age of 21
- Parent-Child Interaction Therapy for individuals under the age of 21
- Therapeutic Behavioral Services for individuals under the age of 21

- Therapeutic Foster Care for individuals under the age of 21
- All Other Medically Necessary SMHS for individuals under the age of 21

1. **The county behavioral health system has opted to provide the specific Medi-Cal SMHS identified as of June 30, 2026:**
 - Clubhouse Services
 - Enhanced CHW Services
 - Peer Support Services
2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? No**

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

1. **The county behavioral health system participates in the following:**

DMC-ODS Program

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

The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the).

- Care Coordination Services
 - Clinician Consultation
 - Outpatient Treatment Services (ASAM Level 1)
 - Intensive Outpatient Treatment Services (ASAM Level 2.1)
 - Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
 - Mobile Crisis Services
 - Recovery Services
 - Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
 - Traditional Healers and Natural Helpers
 - Withdrawal Management Services
 - All Other Medically Necessary Services for individuals under age 21
 - Early Intervention for individuals under age 21
1. **The county behavioral health system has opted to provide the specific Medi-Cal SUD services identified as of June 30, 2026:**
 - Enhanced Community Health Worker (CHW) Services
 - Inpatient Services (ASAM Levels 3.7 & 4.0)
 - Peer Support Services
 - Recovery Incentives Program (Contingency Management)
 2. **Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? No**

Other Programs and Services

1. **The following is a list of other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs:**

SAPC Programs:

- Non-DMC-ODS SUD prevention, youth, and perinatal services (funded through

the federal Substance Use Block Grant.

- Overdose surveillance and reporting (funded through the federal CDC Overdose Data to Action grant)
- Women and Children's Residential Treatment Services (funded through state AB188/SB1020)
- Recovery bridge housing programming for up to 180 days in a 12-month period, with the possibility of an additional 180 days if they have not yet secured permanent/stable housing, to people experiencing homelessness who choose abstinence-based housing (LA County Measure H Funding)
- Permanent Supportive Housing rental subsidies and services including on-site outreach, assessment, and service navigation (LA County Measure H funding)
- Juvenile Justice Programs that provide screening, counseling, family engagement and supportive services, leadership and mentoring (funded through Juvenile Justice Crime Prevention Act, Probation Dept. Juvenile Justice Realignment Block Grant (JJRBG), and DOJ funds)
- Driving Under the Influence (DUI) programs (funded through state DUI funds)
- Interim Housing Outreach Program (IHOP) services: education, engagement, navigation, and harm reduction services (funded through MHSA innovations funding)

DMH programs:

- Mental Health Wellness Grant Program for Children and Youth (CY Grant Program) for Crisis Stabilization Units, Martin Luther King, Olive View Restorative Care Villages, and High Desert Restorative Care Village
- Housing and Homelessness Incentive Program
- Child and Youth Behavioral Health Initiative Grant
- Community Care Expansion Preservation Grants Program
- Temporary Personnel Services-SAMHSA Emergency Response Grant
- Mental Health Student Services Act Grant (MHSSA Grant)
- SAMHSA-SERG Grant: Los Angeles County Recovery Efforts and Building Urgency into Implementation of Long-Term Disaster Support

Care Transitions

1. **Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)?** Yes
2. **Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?** Yes

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 to strengthen their evaluation and better understand community needs.

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

Access to Care: Primary Measures

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

1. **How does your county status compare to the statewide rate?**
 - a. **For adults/older adults:** above
 - b. **For children/youth:** above
2. **What disparities did you identify across demographic groups or special populations?**
Race or Ethnicity and Sex

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

1. **How does your county status compare to the statewide rate?**
 - a. **For adults/older adults:** below

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

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

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

1. **How does your county status compare to the statewide rate?**
 - a. For adults/older adults: N/A
 - b. For children/youth: N/A
2. **What disparities did you identify across demographic groups or special populations?**
No disparities data available

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

1. **How does your county status compare to the statewide rate?**
 - a. **For adults/older adults:** below
 - b. **For children/youth:** below
2. **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

1. **How does your county status compare to the statewide rate?** above
2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

Access to Care: Disparities Analysis

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

Measure 1 examines disparities in penetration rates for adults ages 21 and over who received one or more Specialty Mental Health Services through a Medi-Cal Mental Health Plan in Los Angeles County in 2022, disaggregated by race and ethnicity. The data show that Asian Pacific Islander and Hispanic adults are underrepresented in service penetration, with rates of 0.64 and 0.69, respectively. In contrast, Alaska Native/American Indian, Black, and White adults are overrepresented, with penetration rates of 3.49, 2.29, and 1.66, respectively.

Measure 2 examines disparities in penetration rates among children and youth under age 21 who received one or more Specialty Mental Health Services through a Medi-Cal Mental Health Plan in Los Angeles County in 2022, disaggregated by race and ethnicity. The data indicate that Asian Pacific Islander and White children and youth are underrepresented in service penetration, with rates of 0.28 and 0.54, respectively. In contrast, Alaska Native/American Indian, Hispanic, and Black children and youth are overrepresented, with penetration rates of 25.09, 1.21, and 1.15, respectively.

Measure 3 examines disparities in penetration rates for adults ages 21 and over who received one or more non-specialty mental health services through a Mental Health Plan in Los Angeles County in 2022, disaggregated by race and ethnicity. The data show that Hispanic and Asian Pacific Islander adults are underrepresented in non-specialty mental health service penetration, with rates of 0.79 and 0.86, respectively. In contrast, Alaska Native/American Indian, White, and Black adults are overrepresented, with penetration rates of 2.05, 1.86, and 1.34, respectively.

Measure 4 examines disparities in penetration rates among children and youth under age 21 who are enrolled in a Medi-Cal managed care plan and received one or more non-specialty mental health services in 2022, disaggregated by race. The data indicate that White, Black, and Asian Pacific Islander children and youth are underrepresented in non-specialty mental health service penetration, with rates of 0.62, 0.76, and 0.79, respectively. In contrast, Hispanic and Alaska Native/American Indian children and youth are overrepresented, with penetration rates of 1.19 and 1.09, respectively.

In terms of SUD specific services, LA County's adult population falls below (0.9%) the statewide Drug Medi-Cal Organized Delivery System (DMC-ODS) median penetration rate (1.5%). Additionally, in LA County Latinxs consistently accounted for the largest proportion of all SUD treatment admissions, which also increased from 48% in FY17-18 to 56% in FY22-23. Moreover, among those receiving SUD services, at admission, 54.5% of patients reported having mental health issues, 42.3% were homeless, and 20.0% were involved in the criminal justice system for FY-23-24.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified various interrelated factors driving disparities in access to care. Discrimination and stigma continue to create significant barriers for some populations, discouraging individuals from seeking or remaining engaged in services. Limited provider competency further compounds these challenges, particularly due to a lack of affirming care for LGBTQ+ individuals. In addition, poor accessibility persists as a result of insufficient culturally appropriate and affirming treatment options. Stakeholders also noted a lack of coordination between homeless services and mental health and substance use programs, which undermines continuity of care. Finally, complex entry systems—especially documentation requirements—present additional barriers that restrict timely access to treatment.

Overarching Solutions: Stakeholders identified several overarching solutions to address these factors and increase access to care. These include enhancing housing, outpatient, and other supportive services to reduce barriers that limit individuals' ability to engage in care. Stakeholders also emphasized the importance of increasing outreach and engagement efforts to reach communities beyond existing client populations. Improving provider competencies through targeted training was identified as a critical strategy for expanding access to affirming care, particularly for underserved groups. In addition, strengthening collaboration across systems of care—such as housing, mental health, and substance use services—was seen as essential for improving care integration and continuity. Stakeholders further highlighted the need to provide more flexible, low-barrier care options that meet people where they are. Finally, ensuring accurate and inclusive data

collection was identified as a key step in improving understanding of the LGBTQ+ population and informing more responsive service planning.

Access to Care: Cross-Measure Questions

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

DEPARTMENT OF MENTAL HEALTH (DMH)

Data used to inform DMH programming and interventions:

- Countywide police and mental health co-responder teams in Los Angeles County (LACDMH staff with local police): demographics, incident counts, and hospitalization data to evaluate interventions for a diverse population.
- Mobile crisis response teams: analysis of incidents by service area, time of day, referral source, demographics, and incident outcomes; evaluations for involuntary detention and triage of high-risk or mentally ill individuals.
- California Institute of Behavioral Health Services (CIBHS) SDR Program Participant Questionnaire: data from the Stigma Discrimination Reduction program assessing participants' attitudes, knowledge, and behaviors related to stigma, plus program quality and demographics.
- California Institute of Behavioral Health Services (CIBHS) SP Program Participant Questionnaire: a multiple-choice survey measuring the impact of programs on participants' attitudes, knowledge, and behaviors related to suicide, program quality, and participant demographics. Cost and utilization data from a preliminary analysis comparing clients in early psychosis versus standard care.
- Level of Care Utilization System (LOCUS)
- Universal Entry Referral form

LACDMH has implemented usage of the DHCS Screening Tool within our 24/7 call center and has been conducting analysis of the screeners completed by call agents. The Quality Assurance Unit has implemented procedures to identify agents who may be skipping the completion of the screener and evaluating the reasons for lack of completion. The DHCS Screening Tool usage is critical in ensuring Members are accessing the most appropriate system of care (SMHS/NSMHS) to best meet their behavioral health needs. In addition, LACDMH has implemented the LOCUS to assist clinical teams in identifying clients whose recovery has progressed in a way to no longer need SMHS and may be transitioned to NSMHS. LACDMH is finalizing Clinical Practice Parameters to aid in the transitioning of clients to NSMHS.

DMH is working to improve access to care through the following programs and services:

- **Clubhouse:** By providing local locations for clients to visit daily to foster a sense of community, belonging, and empowerment, while teaching skills transferable to employment, the Clubhouse creates a new access point within our care system. Clubhouses offer voluntary lifelong membership, a "work ordered day," supported employment and education, holistic support beyond clinical care, peer support and social connection, and a reduction in hospitalizations.

- Full-Service Partnership (ACT/FACT & FSP-ICM)
 - Assertive Community Treatment (ACT): Multidisciplinary, community-based teams support individuals with SMI or co-occurring SMI and SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments. The goal is to help individuals manage symptoms, function in the community, obtain/maintain employment and housing, and build social ties.
 - Forensic ACT (FACT): An ACT variant for justice-involved individuals, with enhanced training and staffing, including a team member with lived criminal-justice experience. In many cases, ACT and FACT are delivered by the same teams.
 - Full-Service Partnership – Intensive Case Management (FSP-ICM): A team-based, recovery-focused model with lower intensity than ACT/FACT, serving individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, justice-involved, or at risk, and experiencing moderate functional impairments.
- Peer Respite: Peer respites expand access points across the county, offering non-traditional, distress-focused care for individuals not yet in crisis, and providing a local avenue for support.
- Crisis Residential Treatment Program (CRTP) CRTPs provide stabilization as an alternative to emergency services and inpatient psychiatric care, enabling timely access to higher-acuity settings for those in greater need. They offer therapeutic activities and skills to support transitions back to community living.
- Crisis Stabilization: Provides immediate, 24/7 crisis access, including walk-ins, Psychiatric Mobile Response Teams (PMRTs), Law Enforcement Drop Off, and Urgent Care Centers (UCCs). The goal is to de-escalate crises, connect clients to services, and avoid higher levels of care. Follow-up within 24 hours ensures ongoing connections or in-home/phone support to link clients to services.
- Enriched Residential Services (ERS): ERS serves as a step-down in the mental health care continuum from inpatient and locked treatment settings, maintaining engagement with services and stability in the community, and creating capacity for longer-term residential treatment when needed.
- Law Enforcement Teams (LET): LETs respond to 911 calls related to mental health with the aim of connecting individuals to services, reducing subsequent calls, and preventing hospitalizations.
- Day Treatment Intensive/Day Rehabilitation (DTI/DR): DTI/DR assists clients transitioning from acute/crisis care to higher-intensity outpatient stabilization, enhancing the continuum of care with intensive community-based intervention when routine outpatient visits are insufficient.
- EPI-LA Program/Coordinated Specialty Care – First Episode Psychosis Service: Serving youth and adults ages 12–40 experiencing attenuated psychosis or a first psychotic episode, EPI-LA prioritizes rapid intake and timely access to medications when needed. The program has eight provider sites and plans to expand to high-need areas. Funding: MHSA/BHSA Early Intervention + EPSDT/Medi-Cal.
- Child Medical Hubs: Co-located mental health services within Medical HUB Clinics to ensure access for DCFS-involved children and youth undergoing medical examinations. Services include screenings, crisis intervention, and case management.
- Specialized Foster Care (SFC): SFC provides mental health services and service linkage for child welfare-involved youth and families, aiming to prevent removals or reduce placements. Funding: EPSDT.

- Multidisciplinary Assessment Team (MAT): MAT delivers timely, comprehensive, strength-based assessments for children and youth 0–18 years old to improve early access, coordination, and safety for those in out-of-home placement.
- Hollywood 2.0: A groundbreaking pilot in Hollywood, inspired by Trieste, Italy, and led by the LA County DMH and Hollywood 4WRD. Teams of clinicians, case managers, and community partners deliver comprehensive, person-centered care for people with severe mental illness, leveraging outpatient clinics, interim/permanent housing, and a network of supports to create a recovery-oriented system.
- Veteran & Military Family Services (VMFS): VMFS connects county departments, nonprofits, the VA, and city programs to provide emotional support and specialty mental health services, addressing the needs of veterans and their families.
- Women’s Wellbeing (WWC): WWC offers a women-centered space designed around peer support, with Community Health Workers guiding daily stressors, mental health therapy, and occupational therapy to support well-being and vocational goals. Inclusive of transgender and gender-diverse individuals.
- Therapeutic Shelter Homes (TSHs): TSHs provide up to 10 days of temporary residential care for children and youth who have experienced abuse or neglect (WIC Section 300), with option to serve NMDs ages 18–21 in LA County.
- Qualified Individual (QI): QI assessments determine the most appropriate, least restrictive setting for children/youth/NMDs in child welfare or probation systems, supporting family-based placement and long-term stability.
- DYD - Credible Messengers: This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.
- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.
- DCFS - Prevention and Aftercare: Ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Dept. of Arts & Culture - Creative Wellbeing: A non-traditional, arts and culture–based approach for promoting mental health in young people and caregivers. The model offers non-traditional strategies for promoting mental health and wellness that include culturally relevant, healing-centered, arts-based workshops for youth, as well as professional development, coaching, and emotional support for the adults who work with them. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing.
- Antelope Valley Community Family Resource Centers (CFRC on wheels): The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated

(public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing.

- CFRCs (Supervisory Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.
- Friends of the Children (FOTC): FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and create opportunities for culturally responsive community and peer-to-peer connections.
- Wolf Connection: This is a youth empowerment program, wolfdog rescue center, and sanctuary. Wolf Connection offers unique education and empowerment programs that transform lives via experiential relationships and interactions with rescued wolves and the natural environment. Wolf The “Power of the Pack” program is an immersive digital education and empowerment experience for students aged 11-18. This is a hybrid online/in-person programming with 12 online education lessons and empowerment program for youth. Wolf Connection Team visits sites to facilitate wolf-based education (with or without wolves). Single-day visit onsite at the Wolf Heart Ranch are used as an incentive or as a celebration of the completion of the online program.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods. Their services encompass community outreach, facilitating mental health workshops to combat stigma, making referrals to mental health services, and providing mental health support and triage services based on community needs.
- Community Partners - United MH Promoters: A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training). Focuses on strengthening our communities and creating career paths for community members The program provides for eight UMHP teams/contractor agencies per Supervisory District with nine staff members per team.
- NAMI Urban LA & Greater LA: Provides Countywide community-based prevention programs and approaches and supports to reduce stigma and discrimination targeting people living with mental illness, their families, friends and communities. Activities/services include supports to families and communities navigating mental health treatment and recovery resources, evidence-based education classes, training, and advocacy.
- SEED LA : The SEED School of Los Angeles (SEED LA) is the county’s first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school while provide on-site support, wellness services and socio-emotional counseling for students.
- Birth to Five Mental Health: The Birth-to-5 Team provides capacity building support

including workshops, technical assistance, and reflective consultation to help clinicians effectively support young children and their families. These supports increase access to early relationship centered care and strengthen clinicians' ability to identify developmental and behavioral health needs and connect families to appropriate resources. By addressing concerns early and strengthening caregiver child relationships the Birth-to-5 Team helps prevent escalation to crisis driven responses such as higher levels of care or later justice or DCFS involvement. This early intervention stabilizes families and supports children in remaining safely at home and promotes stronger engagement in early learning and school settings.

- **Parental Perinatal Mental Health:** The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.
- **Parent Partner Academy:** Parent Partner training improves the skills of the Peer Support Specialists (PSS) working with the parents/caregivers of the children receiving services. Improved training of the PSS improves parent/caregiver ability to access needed programs, resources, and additional support which reduces risks of child being removed from home and justice involvement/institutionalization. PSS are better trained to help families access programs to receive treatment for untreated BH health conditions such as Regional Center and increase School Engagement
- **Suicide Prevention, Intervention and Postvention:** Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- **Co-Occurring Intellectual/Developmental Disabilities:** Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.
- **UMHP:** This project invests in communities through contracting with agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and "community member with lived experience." The project utilizes training to build staff skills and support community members' pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home,

untreated behavioral health conditions and increased school engagement). A composite of services are provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).

DEPARTMENT OF PUBLIC HEALTH – SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- Los Angeles County Helpline for Mental Health and Substance Use Services Call Log - the Helpline is a toll-free call line that helps connect individuals (youth, young adults, and adults), who are seeking MH and SUD services with appropriate providers throughout Los Angeles County. The call log provides a record of calls made to the helpline to help assess demand for SUD and MH services.
- Client Engagement and Navigation Services (CENS) Call Log –The CENS call log provides a record of calls made to CENS providers to help assess demand for services.
- Medications for Addiction Treatment (MAT) consultation line Data - The call line fields between 600-700 calls annually, showing level of demand for MAT services.
- American Society of Addiction Medicine (ASAM) Level of Care Data - ASAM criteria-based screening and assessment data to monitor appropriate use of ASAM criteria in the DMC-ODS.
- Listening Sessions with DPH-SAPC Providers and Youth – DPH-SAPC led listening sessions to gather feedback that informed RYSE program development.
- Bureau of Labor Statistics Data – provides data on SUD provider workforce to inform to determine training and capacity building needs.
- Substance Abuse and Mental Health Services Administration (SAMHSA) Report on the 2019 National Survey on Drug Use and Health (NSDUH) – a summary of key findings for national indicators of substance use and mental health among the civilian, noninstitutionalized population aged 12 or older in the United States.
- DPH-SAPC Provider Data – information on DPH-SAPC providers from the LA County SUD EHR information system that includes clinical documentation, data collection, and claims.
- DPH – SAPC Annual Report – An annual overview of clients who received SUD treatment in publicly funded treatment programs in Los Angeles County.

DPH-SAPC is working to improve access to care through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC's Reaching the 95% (R95) Initiative focuses on reaching the 95% of people with SUD who either do not think they need help or are not interested in services by enhancing outreach and engagement and establishing lower barrier care across the

SUD system. SAPC also has an open contracting process to increase service capacity.

- DPH-SAPC's Client Engagement and Navigation Services (CENS) provide in-person SUD services including education, outreach and engagement, screening and referral, and service navigation to facilitate access to care and completion of SUD treatment. SAPC is expanding CENS by better leveraging Medi-Cal and other funding sources.
- DPH-SAPC's field-based SUD services team partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in field-based settings. SAPC is actively adding field-based SUD service sites.
- DPH-SAPC's MAT Consultation Line and the California Bridge program, a statewide independent program, work with hospital EDs to provide immediate access to MAT to anyone seeking help and provide care navigation to increase likelihood of completing follow-up treatment.
- DPH-SAPC's Reimagining Youth SUD Engagement (RYSE) initiative aims to transform youth SUD by tailoring youth SUD services to enhance engagement and retention in care, which can prevent the need for institutionalization.

The following are related initiatives and programs that will increase DPH-SAPC's overall system capacity to serve individuals with SUDs.

- The Tuition Incentive Program (TIP) offers individuals an opportunity to become a certified-eligible SUD Counselor while gaining practical in-the-field experience. The program helps increase the availability of registered and certified SUD counselors, who can support effective, long-term recovery and increase access to care for those affected by substance use in Los Angeles County.
- DPH-SAPC provides Capacity Building Payment funds to a treatment provider in advance to ensure start-up funds to provide services or after the fact to compensate a treatment provider for completing work. The funds support DPH-SAPC's provider network in workforce development, access to care, and fiscal and operational efficiency to prepare for changes resulting from the CalAIM initiative and the movement towards value-based care under payment reform.
- DPH-SAPC provides start-up funds as part of the Residential Capacity Building Pilot for staffing to increase co-occurring capabilities and withdrawal management in residential settings. Additional staffing helps increase access to care.

For the access to care measure, DPH-SAPC recognizes the gap between LA County's DMC-ODS penetration rate and the statewide rate and has implemented programs to address systematic barriers to care for the community and for priority populations (i.e. people experiencing homelessness, youth and transition aged youth, and co-occurring disorders). DPH-SAPC uses SUD treatment admissions data, SUD provider and claims data, and SUD client level data among other sources to develop a holistic baseline and guide programmatic roadmaps and will incorporate statewide behavioral health goal measures in our ongoing data driven decision-making processes.

Firstly, recognizing that only ~5% of individuals with SUD are accessing treatment services, DPH-SAPC launched the Reaching the 95% initiative (R95), which aims to move the SUD treatment system to lower barrier and on-demand care. This long-term initiative seeks to increase treatment provider capacity and enhance demand for services from the community through incentives, network capacity building, and public campaigns and education – contributing to increased penetration rates. This will also address community

feedback through the Community Planning Process regarding ongoing stigma and lack of awareness that may result in less engagement with SUD services.

For youth and transition-aged youth, DPH-SAPC's Rethinking Youth SUD Engagement (RYSE) recognizes the low penetration rate among youth and aims to reimagine and tailor youth SUD services to enhance engagement and retention. Applying a service design approach, DPH-SAPC is leveraging insights and data gleaned from youth listening sessions and providing one-time CBO funds to enhance engagement and retention.

DPH-SAPC's Annual Treatment Reports also highlight other gaps and priority populations. The data in this report goes down to the supervisory district level, aiding in planning for areas of most need. According to the FY '24-'25 report, 58% of clients served reported having mental health issues and 44.1% were experiencing homelessness. DPH-SAPC has addressed these known needs by building co-occurring capacity through workforce development programs, including the Residential Capacity Building Pilot, and by continuing to expand recovery-oriented housing capacity, including Recovery Bridge Housing (RBH), Recovery Housing (RH), and Permanent Supportive Housing (PSH), and navigation services through CENS to facilitate access to care and completion of SUD treatment. BHSAs housing intervention funds will partially contribute to these housing programs.

Finally, to improve access to SUD services for adult, child, and youth populations, DPH-SAPC continues to establish and evaluate program outcomes, conduct needs assessments and expand or adjust SUD programs to increase SUD penetration rates. Understanding service utilization, emerging trends, and unmet needs helps SAPC continue to engage in data driven decision-making, increasing SUD care access and retention.

2. The following is a category or categories of funding that the county is using to address the access to care goal:

- BHSAs Behavioral Health Services and Supports (BHSS)
- BHSAs Full Services Partnership (FSP)
- BHSAs Housing Interventions
- 2011 Realignment
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS))
- Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)
- Other: County General Fund, EPSDT/Medi-cal, Medicaid Expansion, MCHIP

Homelessness

Homelessness: Primary Measures

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

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

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

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

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

Homelessness: Supplemental Measures

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

1. **How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?** above
2. **What disparities did you identify across demographic groups or special populations?**
Gender and Race or Ethnicity

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

1. **How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?** above
2. **What disparities did you identify across demographic groups or special populations?**
Gender and Race or Ethnicity

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

1. **How does your local CoC's rate compare to the average rate across all CoCs?** above
2. **What disparities did you identify across demographic groups or special populations?**
Gender and Race or Ethnicity

Homelessness: Disparities Analysis

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

Measure 1 presents disparity data for persons experiencing homelessness by race and ethnicity based on the January 24, 2024, Point-in-Time Count. The findings indicate that Asian Pacific Islander and Hispanic individuals are underrepresented among the population experiencing homelessness, with disparity ratios of 0.19 and 0.75, respectively. In contrast, American Indian/Native American, Black, and White individuals are overrepresented, with disparity ratios of 14.83, 2.97, and 1.61, respectively.

Measure 2 presents disparity data for persons experiencing homelessness by gender based on the January 24, 2024, Point-in-Time Count. The data indicate that women are underrepresented among individuals experiencing homelessness, with a disparity ratio of 0.62. In contrast, men are overrepresented, with a disparity ratio of 1.38.

Measure 3 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by race and ethnicity, using disparity ratios based on homeless population counts. Drawing on FY 2023–24 treatment admission data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System and comparing these data to population estimates from the 2024 Greater Los Angeles Homeless Count, the analysis reveals notable inequities in treatment access and engagement. Hispanic and White individuals are overrepresented among SUD treatment admissions relative to their representation in the homeless population, with disparity ratios of 1.26 and 1.20, respectively. Asian Pacific Islander individuals are slightly overrepresented, with a ratio of 1.06. In contrast, Black individuals and Alaskan Native or American Indian individuals are underrepresented in SUD treatment admissions, with disparity ratios of 0.58 and 0.54, respectively. Individuals categorized as “Other” are the most underrepresented, with a disparity ratio of 0.19.

Measure 4 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by race and ethnicity, using disparity ratios based on homeless population counts. Using FY 2023–24 treatment admission data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System, and population estimates from the 2024 Greater Los Angeles Homeless Count, the measure highlights persistent inequities in access to SUD treatment. The data show that Hispanic and White individuals are overrepresented among SUD treatment admissions relative to their representation in the homeless population, with disparity ratios of 1.26 and 1.20, respectively. Asian Pacific Islander individuals are also slightly overrepresented, with a disparity ratio of 1.06. In contrast, Black individuals and Alaskan Native or American Indian individuals are underrepresented in treatment admissions, with disparity ratios of 0.58 and 0.54, respectively. Individuals categorized as “Other” are the most underrepresented, with a disparity ratio of 0.19.

Measure 5 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by age group, using disparity ratios based on homeless population counts. The analysis draws on FY 2023–24 treatment admission data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System, compared against age-specific population estimates from the 2024 Greater Los Angeles Homeless Count. The data show substantial variation in treatment admissions across age groups. Young adults ages 18–24 and 25–34 are notably overrepresented in SUD treatment admissions, with disparity ratios of 1.77 and 1.81, respectively. Adults ages 35–44 are also overrepresented, with a ratio of 1.39. In contrast, children and youth ages 0–17 are almost entirely absent from treatment admissions, with a disparity ratio of 0.01. Older adults are consistently underrepresented, including those ages 45–54 (0.72), 55–64 (0.51), and 65 and older (0.28).

Measure 6 examines disparities in substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by gender identity, using disparity ratios based on homeless population counts. This analysis draws on FY 2023–24 treatment admission data from the California Outcome Measurement System and Los Angeles County Participant Reporting System, compared against gender-specific population estimates from the 2024 Greater Los Angeles Homeless Count. The data indicate that males are slightly overrepresented in SUD treatment admissions, with a disparity ratio of 1.05, while females are slightly underrepresented, with a ratio of 0.94. Transgender individuals are substantially overrepresented, with a disparity ratio of 11.48, indicating a

markedly higher rate of SUD treatment admissions relative to their representation in the homeless population. In contrast, individuals categorized as “Other” are significantly underrepresented, with a disparity ratio of 0.05.

Measure 7 examines substance use disorder (SUD) treatment admissions among people experiencing homelessness in Los Angeles County by LGBTQ+ status, using FY 2023–24 data from the California Outcome Measurement System and the Los Angeles County Participant Reporting System. The data show that the majority of individuals admitted to SUD treatment identified as heterosexual, accounting for 85.3 percent of admissions. Smaller proportions of admissions were reported among individuals identifying as bisexual (3.5 percent), gay (2.8 percent), lesbian (1.1 percent), and transgender (1.0 percent). An additional 1.2 percent identified as questioning or unsure, while 5.3 percent of records were categorized as “prefer not to state” or not available. While heterosexual individuals comprise the largest share of admissions, the presence of LGBTQ+ individuals—particularly those identifying as bisexual, gay, lesbian, transgender, or questioning—highlights the importance of affirming and inclusive SUD treatment services.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving these disparities. Substance use trends were highlighted as a key concern, including the ease of access to marijuana and alcohol for minors. Early substance use, often beginning in middle school, is frequently linked to experiences of trauma, poverty, and peer pressure. Economic barriers also play a significant role, as the high cost of living, limited availability of affordable housing, and ongoing financial instability make it difficult for families to remain stably housed. In addition, gaps in mental health care and substance use treatment persist, particularly for youth and transitional-age populations who face limited access to age-appropriate services. Stakeholders further noted challenges in navigating complex systems, such as long wait times, confusing enrollment processes, and limited transportation options, all of which impede access to support. Workforce shortages were identified as another critical issue, with insufficient numbers of trained and culturally competent providers and programs often forced to reduce hours or close early due to staffing constraints. Finally, systemic racism and inequality—including income disparities, disproportionate involvement with the justice and child welfare systems, and provider bias—continue to perpetuate housing instability and unequal access to care.

Overarching Solutions: To address these disparities, stakeholders proposed a set of overarching solutions focused on prevention, access, and accountability. Central to these recommendations is the development of strong community partnerships with trusted organizations and faith-based groups to deliver culturally informed services in spaces where individuals and families feel safe. Stakeholders also emphasized expanding youth prevention programs that provide early education on topics such as fatherhood, financial literacy, and the risks associated with substance use, while incorporating engaging activities like sports and the arts to strengthen participation and connection.

In addition, stakeholders called for greater transparency and accountability within housing systems and funding models, including clear public reporting to ensure resources are effectively reaching those most in need. Mobile outreach and peer support were identified as critical strategies, with street-based teams and peer-run recovery programs helping to connect individuals to care earlier and prevent crises from escalating. Improving data

collection was also highlighted as a priority, particularly through partnerships with community-based organizations to gather accurate, disaggregated data by race, age, and family status to better identify and close service gaps.

Finally, stakeholders underscored the importance of addressing economic and housing instability through investments in vocational training, trauma-informed care, and interim housing solutions such as tiny home villages. Strengthening tenant protections was also recommended, including expanded “Know Your Rights” education and enhanced legal safeguards to prevent evictions and housing discrimination.

Homelessness: Cross-Measure Questions

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

DEPARTMENT OF MENTAL HEALTH (DMH)

Data used to inform DMH programming and interventions:

- Demographics of clients served across DMH housing programs in Los Angeles County, by race and ethnicity. Source: Los Angeles Homeless Services Authority (LAHSA) 2024 Greater Los Angeles Homeless Count. Includes the number of clients served by DMH housing programs by Service Area and a comparison of DMH Service Areas with the 2024 LAHSA Count.
- Demographics of clients served in MSHA and other dedicated Permanent Supportive Housing (PSH) units.
- Federal Housing Subsidies Unit (FHSU): demographics of clients served and housing retention rates for LACDMH clients in federally subsidized units.
- Demographics of clients served by Housing Supportive Services Program (HSSP) and DMH-funded Intensive Case Management Services (ICM).
- Los Angeles County Homeless Initiative Impact Dashboard: dashboard tallies derived from data maintained by multiple housing and service providers, standardized and analyzed by the Los Angeles County Chief Information Office.

DMH is working to improve homelessness through the following programs and services:

- Housing Investments: As outlined in the housing section, housing investments include but are not limited to: Interim Housing, Behavioral Health Bridging Housing, Community Care Expansion Preservation Program, Federal subsidies including Continuum of Care, and Housing Choice Vouchers through 11 active contracts with the Housing Authority of the City of Los Angeles and Los Angeles County Development Authority.
- Full-Service Partnership
 - ACT: Community-based, multidisciplinary teams support individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments.

- FACT: An ACT variant with additional training and staffing to serve justice-involved members; teams often deliver both ACT and FACT.
- FSP-ICM: A team-based, recovery-focused model with lower service intensity than ACT/FACT.
- Peer Respite: Peer respites increase access points across the county, offering non-traditional, distress-focused care for individuals not yet in crisis and providing a local avenue for support.
- Crisis Residential Treatment Program (CRTP): CRTPs provide stabilization as an alternative to emergency services and acute psychiatric care, enabling timely access to higher-acuity settings for those in greater need, offering therapeutic activities and skills to support transitions back to community living.
- Crisis Stabilization: Provides immediate, 24/7 crisis access (walk-ins, Psychiatric Mobile Response Teams, Law Enforcement Drop Off, Urgent Care Centers) to reduce mental health-related ER visits. The goal is to de-escalate crises, connect clients to services, and avoid higher levels of care. Follow-up within 24 hours ensures continued connections or in-home/phone support to link clients to services.
- Law Enforcement Teams (LET): LETs respond to 911 calls related to mental health to connect individuals with services, reduce repeat calls, and prevent hospitalizations.
- Enriched Residential Services (ERS): ERS provides a safety-focused, stable, step-down intervention within the mental health continuum to break cycles of homelessness, crises, and re-hospitalization.
- Homeless Outreach & Mobile Engagement (HOME): HOME serves adults 18+ experiencing chronic unsheltered homelessness with profound mental health needs. It delivers specialized mental health services to secure and sustain housing, addressing deficits in daily living, hygiene, and engagement.
- Prevent Homelessness & Promote Health (PH)²: PH² is a joint program by DMH and Housing for Health to address risk factors and build skills that support permanent housing stability and homelessness prevention.
- Veteran & Military Family Services (VMFS): VMFS connects county departments, nonprofits, the VA, and city programs to provide emotional support and specialized mental health services for veterans and families.
- Hollywood 2.0: Hollywood 2.0 is a pioneering pilot in Hollywood, led by LACDMH and Hollywood 4WRD. Multidisciplinary teams collaborate with community partners to deliver comprehensive, person-centered care for people with severe mental illness, leveraging outpatient clinics, interim/permanent housing, and housing-related supports to create a recovery network focused on the person rather than the diagnosis.
- Skid Row Concierge Outreach (SRC): SRC connects individuals experiencing homelessness and mild-to-moderate mental health symptoms in Skid Row to mental health treatment and shelter through field-based care teams and integrated housing case management.
- Interim Housing Outreach Program (IHOP): IHOP deploys multidisciplinary field teams to serve people experiencing homelessness in interim housing sites, addressing gaps in behavioral and physical health treatment, supporting interim housing stability, and facilitating transitions to permanent housing. Services span eight service areas.
- Library Engagement & Access Program (LEAP): LEAP acts as a liaison between LA County Library, DMH, and partner agencies to connect patrons experiencing homelessness and mental illness (and/or co-occurring SUD) to shelter, food, clothing, mental health treatment, and other supports.

- **Promotores:** The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods.
- **Community Partners - United MH Promoters (contracted):** A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services.
- **UMHP:** This project invests in communities through contracting with agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and “community member with lived experience.” The project utilizes training to build staff skills and support community members’ pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home, untreated behavioral health conditions and increased school engagement). A composite of services are provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).
- **Co-Occurring Intellectual/Developmental Disabilities:** Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools.

DEPARTMENT OF PUBLIC HEALTH (DPH) – SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)

Data used to inform DPH-SAPC programming and interventions:

- The Los Angeles Homeless Services Authority (LAHSA) Greater Los Angeles Homeless Count – the annual point-in-time census to estimate the number of people experiencing homelessness.
- DPH – SAPC Annual Report – An annual overview of clients who received SUD treatment in publicly funded treatment programs in Los Angeles County.
- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- LA County Health and Human Services Data - Provides data about health, public health, and services provided to individuals, children, and families.
- LA County Annual HIV Surveillance Report - describes the status of the local HIV epidemic and demonstrates the use of HIV surveillance data to inform prevention,

care, and treatment programs in Los Angeles County.

DPH-SAPC is working to reduce homelessness by growing housing options for individuals with SUD through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC has invested in expanding Recovery Bridge Housing (RBH) and Recovery Housing (RH). These benefits offer PEH concurrently participating in SUD treatment services with up-to 360 days of RBH, and those that have engaged in SUD treatment and/or RBH in the last 90 days at a SAPC provider agency for up-to 365 days of RH. While it is encouraged, concurrent enrollment in treatment is not a condition of residing in RH.
- DPH-SAPC introduced Housing Navigation Services in FY 2024-25 to support and connect PEH to stable housing options. Housing navigators help individuals prepare, find, move into, and retain affordable and permanent housing opportunities.

The following are related services and programs that enable DPH-SAPC to engage with PEH and connect them to housing and housing navigation services:

- DPH-SAPC's Harm Reduction programs remove barriers to treatment and housing services so that the SUD population can access the services needed to transition towards stable housing.
- DPH-SAPC's Directly-Operated Field-Based SUD Services team partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in field-based settings.

2. The following is a category or categories of funding that the county is using to address the homelessness goal:

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- 2011 Realignment
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
- Substance Use Block Grant (SUBG)
- Community Mental Health Block Grant (MHBG)
- Other: Opioid Settlement Funds (OSF), Measure J: Care First Community Investment (CFCI), Tobacco Settlement Funds, Federal Grant: CDC OD2A

Institutionalization

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

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

longer – the least restrictive environment. (no action)]

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

1. **How does your county status compare to the statewide rate/average?**
 - a. **For adults/older adults:** above
 - b. **For children/youth:** N/A
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

1. **How does your county status compare to the statewide rate/average?**
 - a. **14-day involuntary detention rates per 10,000:** N/A
 - b. **30-day involuntary detention rates per 10,000:** N/A
 - c. **180-day post-certification involuntary detention rates per 10,000:** N/A
2. **What disparities did you identify across demographic groups or special populations?**
No disparities data available

Conservatorships, FY 2021 - 2022

1. **How does your county status compare to the statewide rate/average?**
 - a. **Temporary Conservatorships:** above
 - b. **Permanent Conservatorships:** above
2. **What disparities did you identify across demographic groups or special populations?** No disparities data available

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

1. **How does your county status compare to the statewide rate/average?**
 - a. **Crisis Intervention**
 - i. **For adults/older adults:** above
 - ii. **For children/youth:** above
 - b. **Crisis Residential Treatment Services**
 - i. **For adults/older adults:** above
 - ii. **For children/youth:** same
 - c. **Crisis Stabilization**
 - i. **For adults/older adults:** below
 - ii. **For children/youth:** below
2. **What disparities did you identify across demographic groups or special populations?** Race or Ethnicity and Sex

Institutionalization: Disparities Analysis

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

Measure 1 examines disparities in average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over in Los Angeles County in 2022, disaggregated by race. The data indicate that Hispanic adults are underrepresented, with an average of 0.44 inpatient administrative days. In contrast, Black and White adults are overrepresented, with averages of 2.87 and 2.09 inpatient administrative days, respectively.

Measure 2 examines disparities in average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over in Los Angeles County in 2022, disaggregated by sex. The data show that women are underrepresented, with an average of 0.84 inpatient administrative days. In contrast, men are overrepresented, with an average of 1.18 inpatient administrative days.

Supplemental Measure 1 compares the average number of inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over between Los Angeles County and the statewide average. In 2022, Los Angeles County reported an average of 35.3 inpatient administrative days, which exceeds the statewide average of 25.6 days

Supplemental Measure 2 examines average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over by race in 2022, comparing Los Angeles County with statewide averages. Hispanic adults in Los Angeles County experienced an average of 24.54 inpatient administrative days, slightly higher than the statewide average of 23.1 days. White adults had an average of 27.32 days in the county, compared to 22.68 days statewide. Black adults averaged 24.73 inpatient administrative days in Los Angeles County, exceeding the statewide average of 20.62 days. Individuals with unknown race had an average of 30.17 inpatient administrative days in the county, which is lower than the statewide average of 32.78 days.

Supplemental Measure 3 examines average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over by sex in 2022, comparing Los Angeles County with statewide averages. In Los Angeles County, males experienced an average of 26.84 inpatient administrative days, compared to a statewide average of 24.48 days. Females in the county had a higher average of 29.22 inpatient administrative days, substantially exceeding the statewide average of 21.93 days.

Supplemental Measure 4 presents average inpatient administrative days per Medi-Cal Mental Health Plan (MHP) Specialty Mental Health Service (SMHS) for adults ages 21 and over by age group in 2022, comparing Los Angeles County with statewide averages. Adults ages 21-32 in Los Angeles County experienced an average of 24.73 inpatient administrative days, higher than the statewide average of 19.81 days. Those ages 33-44 averaged 24.63 days in the county, compared to 21.11 days statewide. For adults ages 45-56, the county average was 26.28 days, slightly below the statewide average of 26.75 days. A pronounced disparity is observed among adults ages 57-68, who experienced an average of 52.59 inpatient administrative days in Los Angeles County, substantially exceeding the statewide average of 33.42 days. Data for adults age 69 and older were not available at the county level, while the statewide average for this age group was 25.88 days.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving these disparities across the system of care. Incomplete data systems, including high numbers of “unknown” entries and missing demographic categories, obscure who is most in need of services. Exclusion in reporting further compounds this issue, as Asian Pacific Islander communities and certain age groups are not consistently counted or disaggregated. Weak discharge planning was also cited as a significant concern, with patients often leaving institutional settings without stable housing, follow-up appointments, or a clear recovery plan.

In addition, administrative bottlenecks contribute to prolonged hospital stays, as lengthy placement processes keep beds occupied and limit access for new admissions. Stakeholders also noted persistent communication gaps among hospitals, families, and community-based care teams, resulting in fragmented and poorly coordinated care. Limited availability of specialized services—particularly for older adults, individuals with dementia or traumatic brain injuries, and those with severe substance use disorders—further exacerbates inequities. Concerns about the quality of care were also raised, with institutional settings frequently emphasizing containment rather than treatment and recovery. Finally, stakeholders highlighted misaligned performance metrics, noting that existing dashboards prioritize time spent in care rather than meaningful recovery outcomes or long-term community stability.

Overarching Solutions: To address these disparities, stakeholders proposed a comprehensive set of system-level solutions focused on data integrity, care transitions, capacity, and accountability. First, they emphasized the need to improve data quality by collecting complete demographic information—including race, ethnicity, age, and language—and reducing the use of “unknown” categories through staff training and the use of clear, standardized data-collection scripts. Ensuring that Asian Pacific Islander and other historically undercounted communities are consistently included in all datasets and reports was also identified as essential for accurately identifying and addressing inequities.

Stakeholders further highlighted the importance of strengthening transitions from inpatient and institutional settings by requiring clear housing plans, scheduled follow-up visits within seven days of discharge, continuity of medications, and meaningful family involvement prior to discharge. To reduce excessive administrative days, they recommended operational strategies such as daily placement huddles, fast-track pathways for complex cases, and real-time bed inventories to improve system flow and reduce unnecessary delays.

Expanding system capacity was another priority, with calls to invest in geriatric behavioral health beds, co-occurring substance use disorder programs, and flexible funding mechanisms to open additional placements more quickly. Building stronger community-based supports—including expanded Full-Service Partnerships, peer support groups, and self-help connections—was identified as a strategy to reduce rehospitalizations and support long-term stability. Stakeholders also stressed the need to improve care quality within institutional settings by requiring active treatment components, such as therapy, group services, and individualized recovery goals, rather than focusing solely on containment.

Finally, stakeholders underscored the importance of aligning measurement and financing with desired outcomes. They recommended tracking meaningful indicators such as

readmissions, timely follow-up, community tenure, and patient-stated goals, with data disaggregated by race, age, and language. In parallel, they called for fair and sustainable provider funding, including increased reimbursement rates and the use of block contracts or flexible funding, to enable community-based programs to rapidly add staff and expand service capacity.

Institutionalization: Cross-Measure Questions

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

DMH tracks use of locked facilities (such as SNF-STP, MHRC and State hospital beds). These facilities are primarily used when a judge orders a locked treatment setting, as a step down from State hospital, or a hospital when it is medically necessary.

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

DMH

DMH is working to reduce institutionalization through the following programs and services:

- Clubhouse: The Clubhouse model is an evidence-based psychosocial rehabilitation approach that reduces institutionalization by providing community-based supports, meaningful work, and social connection for people with SMI.
- Full-Service Partnership:
 - ACT: Community-based, multidisciplinary teams support individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments.
 - FACT: An ACT variant with additional training and staffing to serve justice-involved members; teams often deliver both ACT and FACT.
 - FSP-ICM: A team-based, recovery-focused model with lower service intensity than ACT/FACT.
- Peer Respite: The Peer Respite program reduces hospitalizations by offering a voluntary, less-coercive alternative to acute care in a safe, home-like environment, with support from peers who have lived experience. Research shows peer respite participants are less likely to use inpatient or emergency services and often experience improved recovery outcomes.
- Crisis Residential Treatment Program (CRTP): CRTPs provide stabilization as an alternative to emergency services and acute psychiatric facilities, ensuring access to higher-acuity settings for those in greater need. They offer therapeutic activities and skills to support transitions back to community living.
- Crisis Stabilization: Provides immediate, 24/7 crisis access (walk-ins, Psychiatric Mobile Response Teams [PMRTs], Law Enforcement Drop Off, Urgent Care Centers [UCCs])

to reduce mental health–related ER visits. The goal is to de-escalate crises, connect clients to services, and avoid higher levels of care. Follow-up within 24 hours ensures ongoing connections or in-home/phone support to link clients to services.

- Day Treatment Intensive/Day Rehabilitation (DTI/DR): DTI/DR provides an alternative to hospitalization and helps individuals live within the community. Intensive Outpatient Services support semi-independent or independent living for those with chronic psychiatric impairments.
- EPI-LA Early Psychosis/Coordinated Specialty Care – First Episode Psychosis: Serving youth and adults aged 12–40 with attenuated psychosis or a first-episode psychosis, EPI-LA prioritizes rapid intake and timely access to medications when needed. The program currently spans eight provider sites with plans to expand. Funding: MHSA/BHSA Early Intervention + EPSDT/Medi-Cal.
- Enriched Residential Services (ERS) provides a safety-focused, stable, step-down intervention within the mental health continuum to break cycles of homelessness, crises, and re-hospitalization.
- Homeless Outreach & Mobile Engagement (HOME) HOME serves adults 18+ experiencing chronic unsheltered homelessness with profound mental health needs. These individuals may have deficits in food security, clothing, shelter, hygiene, and communication, and are often highly avoidant of services. HOME provides specialized mental health services to secure and sustain housing. Funding: MHSA, Medi-Cal.
- Community Re-entry Programs (soon to be FACT): CRP is a forensic program addressing the needs of formerly incarcerated individuals with mental illness and co-occurring substance use issues. The goal is reintegration through mental health treatment, peer support, employment/education opportunities, and strengthened family/social connections.
- Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

3. The following is a category or categories of funding that the county is using to address the institutionalization goal:

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions

- Community Mental Health Block Grant (MHBG)
- Other: EPSDT/Medi-cal

Justice-Involvement

Justice-Involvement: Primary Measures

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

1. **How does your county status compare to the statewide rate/average?**
 - a. **For adults/older adults:** below
 - b. **For juveniles:** below
2. **What disparities did you identify across demographic groups or special populations?**
Race or Ethnicity and Sex

Justice-Involvement: Supplemental Measures

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

1. **How does your county status compare to the statewide rate/average?** below
2. **What disparities did you identify across demographic groups or special populations?** Gender and Race or Ethnicity

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

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

1. **How does your county status compare to the statewide rate/average?** above
2. **What disparities did you identify across demographic groups or special populations?**
No disparities data available

Justice-Involvement: Disparities Analysis

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

Primary Measure 1 presents disparity data for arrest counts for felony and misdemeanor offenses among adults ages 18 and older who are under probation supervision in Los Angeles County in 2022, disaggregated by race. The data indicate that Hispanic adults are underrepresented in arrest counts, with a disparity ratio of 0.93. In contrast, Black and White adults are overrepresented, with disparity ratios of 2.12 and 1.45, respectively.

Primary Measure 2 presents disparity data for arrest counts for felony and misdemeanor offenses among adults ages 18 and older under probation supervision in Los Angeles County in 2022, disaggregated by sex. The data show that females are underrepresented in

arrest counts, with a disparity ratio of 0.40. In contrast, males are overrepresented, with a disparity ratio of 1.67.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified multiple, interrelated factors driving disparities in arrest outcomes. Systemic racism in policing was cited as a primary contributor, with Black and Latino communities experiencing higher arrest rates than other groups. These patterns are rooted in historical inequities, including long-standing over-policing and racial profiling in low-income neighborhoods. Stakeholders also pointed to the criminalization of mental health conditions and substance use disorders, which often results in law enforcement responses in situations that would be better addressed through health and social services. Limited access to high-quality legal defense for low-income individuals and families further exacerbates these disparities, increasing the likelihood of adverse justice outcomes. Family-level factors were also noted, including trauma and the absence of positive role models, which can contribute to early and ongoing justice system involvement among youth. Economic pressures on caregivers—many of whom work multiple jobs—can leave young people with limited supervision and support. Stakeholders additionally highlighted gender disparities in arrest rates, with men disproportionately impacted, alongside growing arrest rates among women. Finally, a lack of community-based supports, such as stable housing, educational opportunities, and access to healthcare, was identified as a structural driver that reinforces justice system involvement.

Overarching Solutions: To address these disparities, stakeholders proposed a comprehensive set of solutions focused on prevention, diversion, and community investment. Central to these recommendations is the expansion of diversion programs and the decriminalization of mental health and substance use-related issues, reducing reliance on punitive responses. Stakeholders also emphasized increasing access to mental health courts and restorative justice programs as alternatives that prioritize treatment, accountability, and healing over incarceration.

Additional strategies include expanding community-based resources for youth and families, alongside free after-school programs and childcare services to reduce young people's exposure to crime and justice system involvement. Strengthening family supports was also identified as critical, with recommendations to provide counseling, legal assistance, and housing stability services to address underlying stressors. Stakeholders highlighted the importance of improving data collection by disaggregating arrest data by race, age, and socioeconomic status, and by integrating multiple data sources—such as probation, treatment, and law enforcement—to gain a more comprehensive understanding of disparities.

Finally, stakeholders called for a shift in funding away from prisons and law enforcement and toward prevention, treatment, and community-based programs. Tailoring evidence-based practices to the cultural and contextual needs of specific populations, combined with ongoing outreach efforts to reduce stigma and increase awareness of available programs, was identified as essential to advancing equity and reducing justice system disparities.

Justice-Involvement: Cross-Measure Questions

- 1. Please describe what programs, services, partnerships, or initiatives the county is**

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

Department of Mental Health (DMH)

Data used to inform DMH programming and interventions:

- Early Psychosis Learning Healthcare Network: Cost and utilization data from a preliminary analysis comparing clients in Early Psychosis care with those receiving Standard Care.
- Countywide police and mental health co-responder teams in Los Angeles County (LACDMH staff with local police): demographics, incident counts, and hospitalization data to evaluate interventions for a diverse population.
- Los Angeles County Office of Diversion and Reentry (ODR) metrics and outcomes:
 - Misdemeanor Incompetent to Stand Trial (MIST) Diversion
 - Felony Incompetent to Stand Trial Program (FIST) Program
- County of Los Angeles Equity Explorer: Criminal justice and safety (detentions, referrals, crisis interventions)
- Los Angeles County data sources from state and local justice and corrections agencies, including:
 - California Board of State and Community Corrections (BSCC) data.
 - Los Angeles County Justice Data Center data.
 - Los Angeles County Probation Department annual reports.
 - Los Angeles County Sheriff's Department custody reports.

LACDMH provides an alternative crisis response option designed to reduce interactions with the justice system for individuals experiencing a mental health crisis. The department tracks trends using data from alternative crisis response pathways to inform program and service investments which includes IST incidence and transitions (court to restoration to hospital vs. community care), bed occupancy, engagement in community treatment, and recidivism indicators. This is a hypothetical, non-causal exploration intended to guide planning with the aim of potentially reducing court involvement and overall IST numbers, though such outcomes fall outside the LACDMH's purview. We incorporate upstream prevention signals (e.g., Early Psychosis) as potential levers to reduce crisis events, while acknowledging measurement challenges.

DMH is working to decrease justice involvement through the following programs and services:

- Full-Service Partnership (ACT/FACT & FSP-ICM)
 - ACT (Assertive Community Treatment): Multidisciplinary, community-based teams support individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, and/or justice-involved with significant functional impairments. ACT helps

- individuals manage symptoms, function in the community, obtain/maintain employment and housing, and build strong social relationships.
- FACT (Forensic ACT): An ACT variant with additional training and staffing to address the needs of justice-involved members. In many cases, teams deliver both ACT and FACT, and FACT teams include a member with lived criminal-justice experience.
 - FSP-ICM: A team-based, recovery-focused model with lower intensity than ACT/FACT. Services are delivered by multidisciplinary teams to individuals with SMI or co-occurring SMI/SUD who are homeless, high utilizers, justice-involved, at risk, or with moderate functional impairments.
 - Peer Respite: Peer respites focus on crisis diversion by providing a space for individuals in distress that avoids hospitalization or law-enforcement involvement.
 - CRP is a forensic program addressing the needs of formerly incarcerated individuals with mental illness and co-occurring substance use issues. The goal is reintegration through mental health treatment, peer support, employment/education opportunities, and strengthened family/social connections.
 - Clubhouse: The Clubhouse model provides community-based supports, employment opportunities, and social connections for people with SMI by addressing social isolation and unemployment—two major factors in recidivism. Through meaningful work and employment support, members develop skills, dignity, and a sense of purpose. A study in the *Psychiatric Rehabilitation Journal* found that criminal justice system involvement was substantially diminished during and after Clubhouse membership.
 - Crisis Residential Treatment Program (CRTP): CRTPs offer a therapeutic setting for individuals experiencing mental health crises who might otherwise be incarcerated, providing stabilization and a pathway to community reintegration.
 - Crisis Stabilization: Crisis Stabilization Units provide immediate, 24/7 access to de-escalate crises and connect families/caregivers to services, offering Crisis Stabilization as an alternative destination to jail. When appropriate, families can transport loved ones to de-escalate crises without 911 involvement.
 - Law Enforcement Teams (LET): LETs deliver real-time crisis response and connection to mental health services in the community, aiming to reduce arrests and hospitalizations.
 - Mental Health Court Linkage: Collaboration with the courts to guide individuals to needed care as an alternative to incarceration settings
 - Day Treatment Intensive/Day Rehabilitation (DTI/DR): DTI/DR expands non-institutional, community-based treatment, enabling individuals to engage in care, learn new skills, and reduce involvement with the criminal justice system.
 - EPI-LA Early Psychosis / Coordinated Specialty Care – First Episode Psychosis: Serving youth and adults aged 12–40 with attenuated psychosis or first-episode psychosis, EPI-LA prioritizes rapid intake and timely access to medications as needed. The program currently spans eight provider sites and plans to expand to high-need areas. Funding: MHSA/BHSA Early Intervention + EPSDT/Medi-Cal.
 - Enriched Residential Services (ERS): ERS addresses root causes of justice involvement—untreated mental illness and housing instability—by providing a community-based, intensive treatment setting as an alternative to jail for individuals with behavioral health needs who are deemed incompetent to stand trial or charged with low-level, non-violent offenses. ERS supports stabilization and a successful transition to community living.

- **DYD - Credible Messengers:** This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.
- **Community Partners - United MH Promoters (contracted):** A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training) Focuses on strengthening our communities and creating career paths for community members The program provides eight UMHP teams/contractor agencies per Supervisory District with nine staff members per team.
- **UMHP:** This project invests in communities through contracting agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and “community member with lived experience.” The project utilizes training to build staff skills and support community members’ pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home, untreated behavioral health conditions and increased school engagement). A composite of services is provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).
- **Co-Occurring Intellectual/Developmental Disabilities:** Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

DEPARTMENT OF PUBLIC HEALTH-SAPC

Data used to inform DPH-SAPC programming and interventions:

- **The California Outcome Measurement System (CalOMS)** - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- **DPH-SAPC Claims Data** – claims data for SUD treatment services submitted by DPH-SAPC providers.
- **In-Custody to Community Referral Program (ICRP) Source List** – a list of partners and organizations that ICRP works with to link clients to SUD services.
- **Co-Occurring Integrated Care Network (COIN Program) Source List** - a list of partners and organizations that COIN works with to link clients to SUD services.

DPH-SAPC is working to reduce the level of justice involvement for those living significant behavioral health needs by participating in the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC and its providers work with LAC-Probation to navigate the protocols at Juvenile Halls/Camps and advocate for appropriate youth SUD services. DPH-SAPC collaborates with probation to provide direct referrals and ensure that SUD treatment for in-custody individuals transitioning to the community are coordinated and delivered with a warm handoff.
- The Alternatives to Incarceration (ATI) Rapid Diversion Program (RDP) is led by the LA County CEO's Alternatives to Incarceration office in partnership with DPH-SAPC contracted providers, Public Defender, City Attorney, District Attorney, and LA Superior Courts. RDP supports defendants experiencing mental health illness, SUD, and co-occurring disorders by diverting them from the justice system into treatment. If the defendant successfully completes treatment, criminal charges will be dismissed.
- DPH-SAPC partners with Community Collaborative Courts (CCC), multi-disciplinary and resource intensive responses to addressing the needs of veterans, persons experiencing chronic homelessness, individuals with a mental illness, victims of sex trafficking, transitional age at-risk youth, and individuals with a SUD.
- In-Custody to Community Referral Program (ICRP) is a partnership program between DPH-SAPC and the Department of Health Services, Correctional Health Services and Whole Person Care, aimed at initiating connections to SUD treatment services and referral of inmates transitioning from custody into the community. DHS-CHS counselors collaborate with SAPC's provider network, coordinating the reintegration of inmates and ensuring a warm handoff to the appropriate level of care.
- Law Enforcement Assisted Diversion (LEAD) Program is a pre-arrest community-based diversion model led by the Office of Diversion and Reentry, with DPH-SAPC contracted providers, the Sheriff's Department and select community-based organizations. LEAD diverts individuals with repeated low-level drug related offenses at the earliest contact with law enforcement to harm reduction-based case management and social services as an alternative to incarceration. CENS counselors provide substance use disorder screening and linkage to treatment at designated co-locations.
- Sentenced Offender Drug Court (SODC) was established in 1998 as an intensive SUD treatment approach. This program includes a mandatory in-custody treatment approach for 90-days in county jail followed by community based, court supervised SUD residential and/or outpatient treatment services for convicted, non-violent felony offenders who are at high risk of returning to incarceration.
- The Los Angeles County Adult Drug Court (ADC) Program addresses the SUD needs of individuals cycling through the justice system. Through a partnership with the Los Angeles Superior Court, District Attorney's Office, Public Defenders' Office and DPH-SAPC contracted Community-Based SUD treatment providers, the ADC provides integrated drug treatment to promote long-term recovery and reduce costs through collaborative efforts of multiple judicial and treatment entities. The ADC addresses the needs of substance abusing individuals who are convicted of felonies and misdemeanors placed on formal probation in lieu of incarceration.
- DPH-SAPC, Probation and DMH implemented the Co-Occurring Integrated Care Network (COIN) program in 2015. COIN provides integrated SUD and mental health treatment to AB 109 participants who have a chronic SUD and severe and persistent mental illness. Clients are referred by the Los Angeles County Superior Court, Revocation Court (Division 83), for residential treatment.
- The Substance Treatment and Re-entry Transition Community (START-Community)

program offers eligible inmates the opportunity to complete the final 90 days of their sentence in a community-based SUD residential treatment facility. Individuals participating in START-Community will remain under the supervision of the Los Angeles County Sheriff's Department for the duration of their treatment. Upon completion/release, step down services including outpatient treatment and/or recovery support services are offered on a voluntary basis.

The following are related services and programs that address at risk or justice-involved populations:

- DPH-SAPC media and education campaigns serve an essential purpose in exposing individuals and communities to messaging that promotes risk reduction of substance use and encourages positive behavior change. These media campaigns use data and community-driven strategies to provide effective traditional, social and other marketing approaches that target high-risk geographic areas. Raising awareness and education can help prevent behaviors that increase the risk of justice involvement.
- DPH-SAPC's BRIDGE program (Building Relationships, Inspiring Development, Growing Engagement) is a family-focused initiative that enhances providers' capacity to deliver supportive services for caregivers and families of youth, particularly youth with complex needs, juvenile-justice involved youth, and those recently released from detention or secure facilities.

2. The following is a category or categories of funding that the county is using to address the justice-involvement goal:

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP)
- BHSA Housing Interventions
- Community Mental Health Block Grant (MHBG)
- Substance Use Block Grant (SUBG)
- Other: Opioid Settlement Funds, Care First Community Investment (CFCI), Tobacco Settlement Funds, Federal Grant: CDC OD2A, AB 109, Juvenile Justice Crime Prevention Act & Youthful Offender Block Grant, MacArthur Foundation's Safety and Justice Challenge, SAPC in-kind funding, AB 10

Removal Of Children from Home

Removal of Children from Home: Primary Measures

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

- 1. How does your county status compare to the statewide rate?** above
- 2. What disparities did you identify across demographic groups or special populations?**
Race or Ethnicity and Sex

Removal of Children from Home: Supplemental Measures

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

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

Child Maltreatment Substantiations (CWIP), 2022

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

Removal of Children from Home: Disparities Analysis

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

Measure 1 examines disparities in point-in-time and in-care counts of children in foster care, including all children with an open child welfare or probation-supervised placement episode in the system. The data show that White and Asian/Pacific Islander children are underrepresented in foster care, with disparity ratios of 0.76 and 0.18, respectively. In contrast, Alaskan Native/American Indian, African American, and Hispanic children are overrepresented, with disparity ratios of 3.96, 2.83, and 1.01, respectively.

Measure 2 examines disparities in point-in-time and in-care counts of children in foster care, including all children with an open child welfare or probation-supervised placement episode in the system, disaggregated by sex. The data indicate that female children are slightly underrepresented, with a disparity ratio of 0.97. In contrast, male children are slightly overrepresented, with a disparity ratio of 1.04.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving disparities in child welfare system involvement. Systemic racism was cited as a foundational issue, with biased standards for parenting and cultural misunderstandings contributing to higher rates of child removal in communities of color. Socioeconomic challenges—including poverty, single-parent households, literacy gaps, and limited access to adequate nutrition and prenatal care—were also identified as significant risk factors that increase family vulnerability. In addition, stakeholders raised concerns about reporting practices, noting that reports from schools and educators are often unsubstantiated yet still trigger child welfare involvement. Persistent data gaps further complicate efforts to understand and address disparities, as missing contextual information and unclear definitions obscure the root causes of system contact. Finally, stakeholders emphasized the enduring impact of historical harm, including past practices of removing children from marginalized communities, which continue to shape present-day policies, perceptions, and outcomes.

Overarching Solutions: To address these disparities, stakeholders proposed a set of solutions centered on cultural responsiveness, coordination, and family support. Key recommendations include expanding culturally responsive services through partnerships with trusted community-based and faith-based organizations and incorporating cultural advocates and brokers to better support families from diverse backgrounds. Stakeholders also emphasized the importance of stronger system collaboration across agencies such as DCFS, schools, and community organizations to share resources, align practices, and

reduce siloed decision-making. In addition, stakeholders called for enhanced navigation support to help families access needed services more easily and without stigma or unnecessary barriers. Policy and practice changes were also recommended, including reevaluating child removal standards, expanding diversion programs, and reducing unnecessary removals whenever safe and appropriate. Improving service accessibility was identified as another priority, with suggestions to offer in-home and virtual services, low-barrier clinics, and culturally specific options tailored to family needs. Finally, stakeholders underscored the need to strengthen workforce diversity by increasing representation of staff from communities most impacted by the child welfare system, in order to build trust and improve outcomes.

Removal of Children from Home: Cross-Measure Questions

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

DMH

Data used to inform DMH programming and interventions:

- Mobile crisis response teams: incident data by service area, time of day, referral source; demographics; incident outcomes; evaluations for involuntary detention and triage of high-risk or mentally ill individuals.
- PAFP data: Los Angeles County data collected using the Parents' Assessment of Protective Factors (PAFP).
- Full Service Partnership (FSP) data: client-level information including hospitalizations, education level, physical health, and justice involvement, tracked before and after FSP services.
- Brief Universal Prevention Program Survey (BUPPS): data from this LACDMH tool measuring protective factors to assess the impact of prevention programs on individuals who accessed prevention services.
- County of Los Angeles Equity Explorer: Education, Department of Children and Family service investigations, referrals, and removals.

DMH is working to decrease removal of children from home through the following programs and services:

- Specialized Foster Care (SFC): SFC offers mental health services and linkage for child welfare-involved youth and families in the community and directly operated clinics. The program aims to prevent removals or minimize multiple placements for youth already removed from home.
- Children's Full-Service Partnership including High Fidelity Wraparound.
- Children and Youth Wellbeing Services (CYWS): CYWS provides targeted, comprehensive care for children, youth, and TAY (Transition Age Youth) ages birth through 25 years identified with complex mental health conditions who meet criteria

to access Specialty Mental Health Services. The services are tailored to address severe behavioral health disorders, improve functional impairment, and increase developmentally appropriate coping skills. Services are delivered by multidisciplinary staff in clinic and field-based settings utilizing evidence-based and community defined practices. Outpatient specialty mental health services aim to decrease symptoms, prevent the necessity for higher level of care, and promote wellbeing, all while supporting children, youth, and TAY, to remain integrated within their families and communities. Family Preservation (FP): FP serves families at risk of or experiencing problems in family functioning, with the goal of reducing out-of-home placement by delivering mental health services and a range of community-based supports to the child/youth and family.

- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services.
- DCFS - Prevention and Aftercare: Ten leading community agencies providing a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Antelope Valley Community Family Resource Centers (CFRC on wheels): The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated (public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing.
- CFRCs (Supervisory Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.
- Friends of the Children: FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and create opportunities for culturally responsive community and peer-to-peer connections.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods. Their services encompass community outreach, facilitating mental health workshops to combat stigma, making referrals to mental health services, and providing mental health support and triage services based on community needs.

- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training) Focuses on strengthening our communities and creating career paths for community members.
- Birth to Five Mental Health: The Birth-to-5 Team provides capacity building support including workshops, technical assistance, and reflective consultation to help clinicians effectively support young children and their families. These supports increase access to early relationship centered care and strengthen clinicians' ability to identify developmental and behavioral health needs and connect families to appropriate resources. By addressing concerns early and strengthening caregiver child relationships the Birth-to-5 Team helps prevent escalation to crisis driven responses such as higher levels of care or later justice or DCFS involvement. This early intervention stabilizes families and supports children in remaining safely at home and promotes stronger engagement in early learning and school settings.
- Perinatal Parental Mental Health: The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.
- Parent Partner Training Academy: Parent Partner training improves the skills of the Peer Support Specialists (PSS) working with the parents/caregivers of the children receiving services. Improved training of the PSS improves parent/caregiver ability to access needed programs, resources, and additional support which reduces risks of child being removed from home and justice involvement/institutionalization. PSS are better trained to help families access programs to receive treatment for untreated BH health conditions such as Regional Center and increase School Engagement.
- UMHP: This project invests in communities through contracting with agencies serving high and highest need areas across the county. Agencies, leveraging their position within the hyperlocal area, recruit, hire, and train staff to serve as trusted representatives and "community member with lived experience." The project utilizes training to build staff skills and support community members' pathway towards goals outlined within the context of Population Health Measures (e.g. reduction in homelessness, institutionalization, justice involvement, removal of children from home, untreated behavioral health conditions and increased school engagement). A composite of services are provided to address community needs such as, outreach/engagement, referral/linkage, psychosocial support activities, and client support services (e.g. housing assistance, household goods, food assistance, diapers, utilities, and other necessities of life).
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven

measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

- Crisis Teams: PMRT provides community-based crisis services for child welfare youth and families, with the aim of preventing families from entering the Child Welfare System or avoiding additional placements for families already involved.

DEPARTMENT OF PUBLIC HEALTH – SAPC

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.

DPH-SAPC is working to reduce removal of children from home through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC’s Pregnant and Parenting Women (PPW) network offers SUD treatment, housing and supportive services, that includes dedicated recovery bridge housing (RBH) beds for PPW clients and their children countywide. RBH is available for up-to five accompanying children (aged 0-16) with a benefit of up-to 360 days. These services are provided to the parent and child(ren) in accordance with DHCS’s Substance Use Disorder Perinatal Practice Guidelines. Services under the PPW program include expanded services to pregnant, postpartum, and parenting women and their dependent children, ensuring access at all levels of care, inclusive of dedicated services available to the children, which include care coordination, child-care, and transportation services. Increasing availability and access to care ensures a child’s well-being and decreases the risk of child removal from the home.
- DPH-SAPC participates in Recovery Support Court, which assists Department of Children and Family Services involved parents in abstaining from substance use and maintaining recovery. Parents receive counseling in different areas including SUD counseling, and mental health services. These services help reduce the risk of being removed from the home for at risk children.
- DPH-SAPC initiated the Recovery Bridge Housing for fathers with dependent children (RBH-DADS) in April 2025. Like RBH for the PPW population, the RBH-Dads is designed to provide temporary housing for men who are receiving outpatient SUD treatment with up to five accompanying children (aged 0-16). The program is intended to support families affected by SUD to remain together, and for those with involvement with the Department of Children and Family Services (DCFS), to work towards reunification. The RBH-DADS program is planned for full implementation across the county by calendar year 2026.

2. The following is a category or categories of funding that the county is using to address the removal of children from home goal

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

- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS))
- Substance Use Block Grant (SUBG)
- Other: EPSDT/Medi-cal

Untreated Behavioral Health Conditions

Untreated Behavioral Health Conditions: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured: below
2. What disparities did you identify across demographic groups or special populations?
No disparities data available

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured: below
2. What disparities did you identify across demographic groups or special populations?
No disparities data available

Untreated Behavioral Health Conditions: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured: below
2. What disparities did you identify across demographic groups or special populations?
Race or Ethnicity and Sex

Untreated Behavioral Health Conditions: Disparities Analysis

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

Primary Measure 1 assesses the percentage of emergency department (ED) visits among members age 13 and older with a principal diagnosis of substance use disorder or any diagnosis of drug overdose that received a follow-up service within 30 days of the ED visit (31 total days), also known as the FUA-30 measure. In this analysis, Health Net Community Solutions, Inc. reported a follow-up rate of 25.83 percent, while LA Care Health Plan reported a slightly higher rate of 26.15 percent. Both plans exceeded the Department of Health Care Services (DHCS), which established minimum performance level of 21.24 percent; however, neither reached the DHCS high performance benchmark of 32.38 percent.

Primary Measure 2 evaluates the percentage of emergency department (ED) visits among members age 6 and older with a principal diagnosis of mental illness or any diagnosis of intentional self-harm that received a mental health follow-up service within 30 days of the

ED visit (31 total days), referred to as the FUM-30 measure. In this analysis, Health Net Community Solutions, Inc. reported a follow-up rate of 39.35 percent, while LA Care Health Plan reported a rate of 35.70 percent. Both plans performed well below the Department of Health Care Services (DHCS) established minimum performance level of 54.51 percent and the high-performance benchmark of 72.01 percent.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors contributing to disparities in follow-up care after emergency department visits. Insufficient care coordination was cited as a major challenge, as emergency departments and outpatient providers often operate in silos with limited communication and inadequate data sharing. Weak discharge planning further compounds this issue, with patients frequently leaving hospitals without scheduled follow-up appointments or clear, actionable care plans. Stakeholders also pointed to system performance gaps, noting that health plans are not consistently meeting minimum or high-performance benchmarks for timely follow-up care. Stigma and misdiagnosis were identified as additional barriers, as negative perceptions of mental illness and substance use can discourage individuals from seeking treatment, while inaccurate diagnoses may result in ineffective or inappropriate care. Structural barriers such as housing instability, lack of transportation, and limited access to phones or digital communication further reduce individuals' ability to attend follow-up appointments. Finally, workforce shortages, including insufficient numbers of trained staff and low compensation—were highlighted as significant constraints that limit service availability and follow-up support.

Overarching Solutions: To address these disparities, stakeholders proposed a set of coordinated solutions that focus on system accountability, holistic care, and improved access to follow-up services. Key recommendations include using policy levers and financial incentives—such as performance-based contracts, increased reimbursement rates, and targeted policy changes—to strengthen follow-up outcomes after emergency department visits. Stakeholders also emphasized adopting a whole person care approach that addresses social determinants of health, including housing stability, employment, and community support, alongside medical and behavioral health treatment.

In addition, stakeholders recommended increasing staffing and system supports by placing care navigators, peer specialists, and community health workers directly in emergency departments to facilitate timely connections to follow-up care. Targeted interventions were also proposed for populations with higher needs, such as mothers with substance use disorders, youth, and individuals experiencing homelessness, to ensure services are responsive and appropriately tailored. Expanding access options through telehealth, mobile outreach, appointment reminders, and culturally responsive service delivery was identified as a critical strategy to reduce logistical and structural barriers. Finally, stakeholders underscored the importance of reducing stigma by engaging peers with lived experience, expanding public and provider education, and normalizing conversations about mental health and recovery.

Untreated Behavioral Health Conditions: Cross-Measure Questions

- 1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may decrease your**

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

DEPARTMENT OF MENTAL HEALTH (DMH)

Data used to inform DMH programming and interventions:

- Countywide police–mental health co-responder data: Data describe LACDMH staff collaboration with local police in Los Angeles County. The dataset covers demographics, incident counts, and hospitalization data to evaluate interventions across the county's diverse population. Additional analyses examine incidents by service area, time of day, referral source, demographics, and incident outcomes for the mobile crisis response teams, which conducted evaluations for involuntary detention and triaged high-risk or mentally ill individuals.
- Early Psychosis Learning Healthcare Network: Cost and utilization data from preliminary analyses comparing clients in early psychosis programs to those receiving standard care.
- Los Angeles County Urgent Care Center data: Metrics include new admissions by age group; clients who received a psychiatric emergency assessment within 30 days of an UCC assessment; clients returning to UCC within 30 days of a prior UCC visit; and clients who were homeless at admission to UCCs.

DMH is working to decrease untreated behavioral health conditions through the following programs and services:

- Crisis Stabilization: A Crisis Stabilization Unit may serve as the initial supportive environment for individuals with emerging psychiatric conditions and can provide linkage to ongoing care. Resolving a crisis without hospitalization is less disruptive and can improve the help-seeking experience.
- Crisis Residential Treatment Program (CRTP): CRTPs provide stabilization as an alternative to emergency services and acute psychiatric facilities, ensuring access to higher-acuity settings for those in greater need. They offer therapeutic activities and skills to support transitions back to community living.
- Law Enforcement Teams (LET): LETs provide crisis services in the community, connecting individuals to mental health services so they can receive ongoing treatment, rather than defaulting to emergency responses.
- EPI-LA Early Psychosis: The EPI-LA Program serves youth and adults aged 12–40 experiencing attenuated psychosis or a first psychotic episode. Clinics contact youth and families within two days of referral for screening; if eligible, intake occurs within 10 business days, with priority for medication services when needed. The program has expanded to eight provider sites and plans to grow further in high-need areas.
- Short-Term Residential Therapeutic Programs (STRTPs): STRTPs provide specialized, intensive care and supervision, supports, and short-term 24-hour care for children/youth/NMDs whose needs cannot be safely met in a family setting.
- Intensive Services Foster Care (ISFC): ISFC is a California Child Welfare Program, a collaboration among DCFS, Probation, and DMH, delivering intensive community-based care for youth with serious emotional and behavioral challenges through specially trained Foster Family Agency teams and Resource Parents. Services are

tailored to the underlying needs of the child/youth and family, with culturally and linguistically humble, respectful delivery.

- **DYD - Credible Messengers:** This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth to paired mentors, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral and resource linkage.
- **First 5 - Home Visitation:** Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services. **DCFS - Prevention and Aftercare:** Ten leading community agencies providing a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- **Antelope Valley Community Family Resource Centers (CFRC on wheels):** The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents. The AV CFRC is designed to create a coordinated (public/private) community owned and driven space, or network of spaces, where families and individuals in the AV can easily access the services they need to enhance their wellbeing.
- **CFRCs (Supervisory Districts 1 - 5):** The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.
- **Promotores:** The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods. Their services encompass community outreach, facilitating mental health workshops to combat stigma, making referrals to mental health services, and providing mental health support and triage services based on community needs.
- **Community Partners - United MH Promoters (contracted):** A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training) . Focuses on strengthening our communities and creating career paths for community members The program provides for eight UMHP teams/contractor agencies per Supervisory District with nine staff members per team.
- **Perinatal Parental Mental Health:** The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational

and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.

- **Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP)** is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- **Co-Occurring Intellectual/Developmental Disabilities:** Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

DEPARTMENT OF PUBLIC HEALTH – SAPC

Data used to inform DPH-SAPC programming and interventions:

- The California Outcome Measurement System (CalOMS) - a data collection and reporting system for substance use disorder (SUD) treatment services. It provides admission, discharge, and annual update data for SUD treatment services.
- DPH-SAPC Claims Data – claims data for SUD treatment services submitted by DPH-SAPC providers.
- DPH-SAPC Provider Data – information on DPH-SAPC providers from the LA County SUD EHR information system that includes clinical documentation, data collection, and claims.
- DPH – SAPC Annual Report – An annual overview of clients who received SUD treatment in publicly funded treatment programs in Los Angeles County.
- American Society of Addiction Medicine (ASAM) Level of Care Data - ASAM criteria-based screening and assessment data to monitor appropriate use of ASAM criteria in the DMC-ODS.
- LA County Health and Human Services Data - Provides data about health, public health, and services provided to individuals, children, and families.
- Provider Progress Notes – DPH-SAPC provider notes for patients receiving SUD treatment services.
- LA County Annual HIV Surveillance Report - describes the status of the local HIV epidemic and demonstrates the use of HIV surveillance data to inform prevention, care, and treatment programs in Los Angeles County.

DPH-SAPC is working to decrease untreated behavioral health conditions throughout LA County through capacity building initiatives across all levels of care, including residential and non-residential services, in the following existing programs, services, partnerships,

and/or initiatives:

- DPH-SAPC is increasing the number of licensed clinicians prepared to assess / treat co-occurring conditions and psychiatric medical clinicians that provide medication support, in order to augment the capacity of outpatient and intensive outpatient services to serve clients with co-occurring mental health conditions in SUD settings.
- DPH-SAPC's Workforce Development and Value-Based Incentives programs are building provider agency capacity to treat residential co-occurring populations in preparation for the ASAM 4th Edition. DPH-SAPC is also communicating that all levels of care must be co-occurring capable at a minimum. Increasing workforce capacity helps reduce the likelihood of untreated BH conditions.
- DPH-SAPC provides start-up funds as part of the Residential Capacity Building Pilot to increase staff capabilities delivering co-occurring and withdrawal management services in 24-hour settings. These funds help increase capabilities of service providers to decrease the chance of untreated BH conditions.

DPH-SAPC is also reducing the level of untreated behavioral health conditions by reaching individuals where they are through the following existing programs, services, partnerships, and/or initiatives:

- DPH-SAPC's Directly-Operated Field-Based SUD Services team partners with existing field-based teams to ensure LA County residents experiencing homelessness have access to SUD services in non-traditional / community-based settings.
- DPH-SAPC's Harm Reduction programs often serve people that are not connected with the county BH system. Awareness, anti-stigma, and education campaigns address entry-barriers to care and increase awareness of treatment options.
- DPH-SAPC offers ASAM 3.3 Population Specific High Intensity residential services in specialty facilities intended for those with significant cognitive impairments, such as traumatic brain injury, related to their SUD or co-occurring mental health disorder. Treatment focuses on rehabilitation and stabilization with an emphasis on building daily living skills. Meeting these specific needs helps decrease the likelihood of untreated BH conditions.
- DPH-SAPC partners with California Bridge, a statewide independent program, which works with hospital EDs to provide immediate access to MAT to anyone seeking help and provide care navigation to increase likelihood of completing follow-up treatment. This program is funded outside of the county behavioral health system but contributes to addressing untreated BH conditions in hospital EDs.

2. The following is a category or categories of funding that the county is using to address the untreated behavioral health conditions goal:

- BHSA Behavioral Health Services and Supports (BHSS)
- 2011 Realignment
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS))
- Substance Use Block Grant (SUBG)
- Other: Behavioral Health Pilot Project, and the CalBridge Behavioral Health Navigator Program (State Opioid Response – SOR grant, SAMHSA), Opioid

Additional Statewide Behavioral Health Goals for Improvement

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

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

Care Experience

Care Experience: Primary Measures

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

1. **How does your county status compare to the statewide rate/average?**
 - a. **For adults/older adults:** above
 - b. **For children/youth:** above

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

1. **How does your county compare to the statewide rate/average?**
 - a. **For adults/older adults:** above
 - b. **For children/youth:** above

Engagement In School

Engagement in School: Primary Measures

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

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

Engagement in School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work

Engagement in Work: Primary Measures

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

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

Engagement in Work: Supplemental Measures

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

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

Overdoses

Overdoses: Primary Measures

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

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

- a. For the full population measured: below
- b. For adults/older adults: below
- c. For children/youth: below

Overdoses: Supplemental Measures

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

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

- a. For the full population measured: below
- b. For adults/older adults: below
- c. For children/youth: below

Prevention And Treatment of Co-Occurring Physical Health Conditions

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

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

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

- a. For adults (specific to Adults' Access to Preventive/Ambulatory Health Service): below
- b. For children/youth (specific to Child and Adolescent Well-Care Visits): below

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

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

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

- a. For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications): above
- b. For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose and Cholesterol Testing): above

Quality Of Life

Quality of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

Quality of Life: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured: above

Social Connection

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured: same
 - b. For adults/older adults: above
 - c. For children/youth: same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides

Suicides: Primary Measures

Suicide Deaths, 2022

1. How does your county status compare to the statewide rate/average?
 - a. For the full population measured: below

Suicides: Supplemental Measures

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

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

County-Selected Statewide Population Behavioral Health Goals

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

Based on your county's performance or inequities identified, select **at least one additional goal** to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below. [multi-select dropdown of statewide goals for improvement and reduction, excluding statewide priority goals] [logic: populate questions below for each goal selected]

1. **Goal #1:** Engagement in School

a. **Please describe why this goal was selected**

There is a larger gap between County and State performance for Engagement in School (1%) than for Engagement in Work (0.2%) and for Prevention & Treatment of Co-Occurring Physical Health Conditions. The primary measure for Engagement in School—12th grade graduation rates—is broad enough to encompass both mental health and substance use disorder (SUD) populations. Engagement in School specifically targets children and adolescents who are BHSA eligible and priority populations. DMH and SAPC maintain strong partnerships with school systems and prevention programs to address these populations.

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

Measure 1 tracks the percentage of twelfth graders who graduated from high school on time, using data from the California Department of Education (January 2024). At the state level, on-time graduation rates increased from 80 percent in 2013 to 87 percent in 2022, reflecting a steady overall upward trend despite minor fluctuations across years. County-level graduation rates followed a similar pattern, rising from 77 percent in 2013 to 86 percent in 2022. While the county consistently trailed the state by a small margin throughout the period, the gap narrowed over time, particularly by 2022. No data were reported by the state for the years 2015 and 2021, limiting year-to-year comparisons for those periods.

Measure 2 examines on-time high school graduation rates for twelfth graders in Los Angeles County by race and ethnicity, using data from the California Department of Education (January 2024). Across all racial and ethnic groups, graduation rates increased between 2019 and 2022, indicating overall progress over time. Asian students consistently demonstrated the highest on-time graduation rates, rising from 91 percent in 2019 to 92 percent in 2022. White students also showed strong outcomes, increasing from 86 percent in 2019 to 90 percent in 2022. Latino students experienced steady improvement, with on-time graduation rates increasing from 81 percent in 2019 to 85 percent in 2022. Graduation rates for Black students rose from 76 percent in 2019 to 79 percent in 2022, reflecting progress but remaining lower than other groups. Students categorized as "Other" also saw gains over time, increasing from 72 percent in 2019 to 82 percent in 2022.

Measure 3 examines the student chronic absenteeism rate for K–12 public schools

in 2022. The data show that the county's chronic absenteeism rate was 22.0 percent, exceeding the statewide rate of 20.4 percent.

Measure 4 presents Los Angeles County's student chronic absenteeism rates for the 2023–24 academic year, disaggregated by race and ethnicity. Significant disparities are evident across student groups. In California, chronic absenteeism eligible enrollment includes students enrolled for at least 31 instructional days during the academic year, and students are classified as chronically absent if they miss 10 percent or more of the school days they are expected to attend. African American students experienced the highest chronic absenteeism rate at 33.9 percent, followed closely by Pacific Islander students at 31.9 percent and American Indian or Alaska Native students at 29.8 percent. Hispanic or Latino students also had elevated absenteeism, with nearly one in four students (24.6 percent) identified as chronically absent. In contrast, Asian students had the lowest chronic absenteeism rate at 6.4 percent, followed by Filipino students at 9.4 percent. White students and students identifying as Two or More Races had similar rates, at 15.7 percent and 15.8 percent, respectively. Students with race or ethnicity not reported had a chronic absenteeism rate of 22.3 percent.

Measure 4, Meaningful Participation at School, draws on the California Healthy Kids Survey (2023) for grades 7, 9, 11, and non-traditional settings and reflects the Los Angeles County average percentage of students who reported "Strongly Agree" or "Agree" that they experience meaningful participation at school. The data show a clear downward trend across all grade levels over time. Among seventh graders, reported meaningful participation declined from 41 percent in 2013–2015 to 25 percent in 2021–2023. Similar patterns are observed for ninth and eleventh graders, with ninth-grade responses decreasing from 35 percent to 22 percent and eleventh-grade responses declining from 36 percent to 24 percent over the same period. Students in non-traditional school settings consistently reported the lowest levels of meaningful participation, decreasing from 28 percent in 2013–2015 to 22 percent in 2021–2023. While the steepest declines occurred between the 2015–2017 and 2017–2019 periods, the most recent data indicate persistently low levels of perceived participation across all groups.

Measure 5 examines meaningful participation at school using data from the California Healthy Kids Survey for 2021–2023, showing the Los Angeles County average percentage of students who reported "Strongly Agree" or "Agree," disaggregated by sexual orientation and grade level. Across most grade levels, students who identified as straight or heterosexual reported higher levels of meaningful participation compared to students who identified as gay, lesbian, bisexual, or not straight, as well as those who were unsure of their sexual orientation. Among seventh graders, 26 percent of straight students reported meaningful participation, compared to 20 percent of students identifying as not straight and 22 percent of students who were unsure. Similar patterns are observed in ninth grade, where 23 percent of straight students reported meaningful participation, compared to 19 percent among not straight students and 21 percent among those who were unsure.

In eleventh grade, reported participation declined across all groups, with straight and not straight students both reporting 25 percent, while students who were unsure

reported lower levels at 19 percent. In non-traditional school settings, patterns differed somewhat, with students who were unsure of their sexual orientation reporting the highest level of meaningful participation at 28 percent, compared to 22 percent among not straight students and 21 percent among straight students.

Measure 6 examines meaningful participation at school using data from the California Healthy Kids Survey (2021–2023), reflecting the Los Angeles County average percentage of students who reported “Strongly Agree” or “Agree,” disaggregated by race/ethnicity and grade level. The data reveal notable variation across racial and ethnic groups, as well as differences by grade. Overall, reported levels of meaningful participation tend to be higher in seventh and eleventh grades and lower in ninth grade across most groups.

American Indian and Pacific Islander students reported some of the widest variation. American Indian students showed relatively high levels of participation in seventh and eleventh grades (33–34 percent), but substantially lower levels in ninth grade (14 percent). Pacific Islander students reported the highest participation among eleventh graders at 38 percent, while ninth-grade participation was markedly lower at 12 percent. Asian students also demonstrated declines in ninth grade, with participation dropping from 29 percent in seventh grade to 22 percent in ninth grade, before increasing again in eleventh grade and non-traditional settings. Latino/a students consistently reported lower levels of meaningful participation compared to other groups, ranging from 20 to 23 percent across grade levels. African American students reported moderate levels of participation, with rates between 23 and 27 percent, while White students reported relatively stable participation across grades, ranging from 24 to 29 percent. Students identifying as Mixed or Other Ethnicity generally reported participation levels in the mid- to high-20 percent range, with some variation by grade.

STAKEHOLDER PERSPECTIVES

Factors Driving Disparities: Stakeholders identified several factors driving disparities in school attendance and engagement. Socioeconomic challenges including poverty, food insecurity, transportation barriers, and homelessness were cited as major obstacles that limit students’ ability to attend school consistently and remain engaged. Environmental trauma also plays a significant role, as exposure to violence, housing instability, and the absence of routine trauma screening contribute to disengagement, particularly among African American youth. Safety concerns were identified as another critical factor, with risks related to commuting, school shootings, and a lack of psychological safety discouraging regular attendance. Stakeholders further highlighted systemic racism within educational settings, including anti-Blackness, biased curricula, and limited racial and cultural representation among educators, all of which perpetuate inequities and undermine student belonging. Finally, data limitations—such as incomplete, siloed, or inconsistent data collection—were noted as barriers to identifying disparities accurately and tracking student engagement over time.

Overarching Solutions: To address these disparities, stakeholders proposed a set of integrated solutions focused on safety, cultural responsiveness, and cross-system coordination. Central to these recommendations is the creation of safe and engaging

learning environments that are culturally affirming and trauma-informed, and that connect academic learning to students' lived experiences and future opportunities. Stakeholders also emphasized the importance of collaboration across education, health, housing, justice, and social service systems to address student needs holistically and reduce barriers to engagement. In addition, stakeholders recommended leveraging Community-Defined Evidence Practices (CDEPs) that are validated and culturally responsive, particularly to address trauma and behavioral health needs among African American youth. Expanding access to targeted supports was also identified as a priority, including resources for students experiencing homelessness, recovery schools, and alternative pathways to graduation. Strengthening data systems was highlighted as essential to advancing equity, with calls for countywide, inclusive data collection that captures all school types, student identities, and relevant risk factors. Finally, stakeholders underscored the need to reduce stigma and promote early intervention by investing in prevention programs, mental health supports, and sustained community partnerships to keep students engaged in school.

- c. **Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Engagement in Schools and refer to any data that was used to make this decision.**

DMH

DMH is working to increase engagement in schools through the following programs:

- Crisis Teams – School Threat Assessment Response Team (START): provides services to children and youth at schools to ensure they receive the supports they need and to help them access additional school-system resources to fully participate in school activities.
- DYD - Credible Messengers: This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services.
- First 5 - Home Visitation: Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family.
- DCFS - Prevention and Aftercare: Ten leading community agencies providing a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of ACEs and social determinants of health.
- Antelope Valley Community Family Resource Centers: The Centers are intended to reimagine service delivery, create career pathways, reduce stigma while also reducing risk factors, improving protective factors and to embrace children, families and communities as change agents.
- CFRCs (Supervisory Districts 1 - 5): The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing.

- Friends of the Children (FOTC): FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care.
- Promotores: The United Mental Health Promoters Program aims to lessen mental health stigma throughout Los Angeles County, particularly in underserved cultural and linguistic groups. Mental Health Promoters engage community members and connect them with the Department of Mental Health and other resources through culturally sensitive methods.
- Community Partners - United MH Promoters (contracted): A community outreach and empowerment effort serving Los Angeles County that provides mental health prevention services (e.g., outreach/engagement, training). Focuses on strengthening our communities and creating career paths for community members
- SEED LA: The SEED School of Los Angeles (SEED LA) is the county's first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school while provide on-site support, wellness services and socio-emotional counseling for students.
- UCLA Public - Public Partnership for Wellbeing: The University of California provides training and educational activities consistent with BHSA for DMH staff, trainees, family members, and peers that strengthens DMH's ability to deliver services to underserved populations in Los Angeles County.
- Birth to Five Mental Health: The Birth-to-5 Team provides capacity building support including workshops, technical assistance, and reflective consultation to help clinicians effectively support young children and their families. These supports increase access to early relationship centered care and strengthen clinicians' ability to identify developmental and behavioral health needs and connect families to appropriate resources. By addressing concerns early and strengthening caregiver child relationships the Birth-to-5 Team helps prevent escalation to crisis driven responses such as higher levels of care or later justice or DCFS involvement. This early intervention stabilizes families and supports children in remaining safely at home and promotes stronger engagement in early learning and school settings.
- Perinatal Parental Mental Health: The Parental Perinatal Mental Health (PPMH) Program is a countywide, multi-layered clinical support initiative designed to strengthen perinatal mental health care in directly operated clinics. The program provides comprehensive training, ongoing coaching, reflective supervision, and technical assistance to support high-quality implementation. PPMH offerings include foundational and advanced web-based courses, evidence-based interventions, specialized trainings to support families during the perinatal period, monthly consultation calls, and a certification pathway to build long-term expertise and sustainability in perinatal mental health care.
- Parent Partner Training Academy: Parent Partner training improves the skills of the Peer Support Specialists (PSS) working with the parents/caregivers of the children receiving services. Improved training of the PSS improves parent/caregiver ability to access needed programs, resources, and additional support which reduces risks of child being removed from home and justice involvement/institutionalization. PSS are better trained to help families access

programs to receive treatment for untreated BH health conditions such as Regional Center and increase School Engagement

- Suicide Prevention, Intervention and Postvention: Partners in Suicide Prevention (PSP) is a program focused on suicide prevention, intervention, and postvention across communities and service systems. The program strengthens awareness, early identification of suicide risk, and create linkages/referrals. PSP also supports effective postvention efforts to promote healing, reduce stigma, and prevent future suicide risk through educational workshops, resources, and partnership.
- Co-Occurring Intellectual/Developmental Disabilities: Individuals with mental health challenges and co-occurring intellectual/developmental disabilities (MH/IDD) are exceptionally vulnerable to fragmented systems, delayed diagnoses, and limited access to coordinated care, all of which increase their risk of inappropriate therapies - equivalent to not having their behavioral health conditions addressed, contributing to the development of severe mental illness (SMI). As a proactive network node, the CO-IDD Program works to break down barriers addressed by all seven measures: to facilitate appropriate access to care, promoting a seamless continuum of supports to prevent or reduce homelessness, institutionalization, justice involvement, removal of children, and engagement in schools. Supporting individuals and their caregivers early reduces crisis episodes, improves outcomes, and enhances quality of life for individuals and families alike.

DEPARTMENT OF PUBLIC HEALTH – SAPC

DPH-SAPC is working to improve engagement in school through the following existing youth focused programs, services, partnerships, and/or initiatives:

- DPH-SAPC contractors offer field-based treatment services on 76 school campuses to help ensure that a student's needs are being met and they remain engaged in school. In addition, DPH-SAPC directly-operated 43 Student Wellbeing Centers on high school campuses that are safe, accessible environments where students can receive guidance, resources, and education on substance use and other related health and social topics to support their physical, emotional, and social wellbeing and reduce substance use. Providing resources at school sites improves access and facilitates engagement in school.
- DPH-SAPC funds LA County Our SPOT (Social Places & Opportunities for Teens), a free, after school teen program offered at county parks, that provides youth ages 12 to 18 with a safe, structured space to build community, develop life skills, and explore leadership, wellness, and career pathways through daily programming, field trips, and special events. Participants can connect with resources and opportunities that reduce risk factors and strengthen protective factors for SUD, while encouraging continued engagement in school.
- DPH-SAPC's Community Engagement Team provides spaces where anyone can come to get information and resources on how to prevent alcohol and substance use and know where to go for

services. Access to prevention resources protect youth from substance use and promote engagement in school.

- DPH-SAPC works with CBOs to provide Prevention Education Programs for substance use health promotion and education services in community settings (e.g., schools, faith-based locations). These programs reinforce positive support systems and community connections, which support greater engagement in school.
- DPH-SAPC funds Friday Night Live, a youth-adult partnership program focused on positive and healthy youth development and creating opportunities for engagement on substance use topics, both of which contribute to increased engagement in school.

d. The following is a category or categories of funding that the county is using to address the Engagement in School goal:

- BHSA Behavioral Health Services and Supports (BHSS)
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System DMC/DMC-ODS)
- Substance Use Block Grant (SUBG)
- Other: Opioid Settlement Funds, EPSDT/Medi-cal

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Community Planning Process

Stakeholder Engagement

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

1. Stakeholder Involvement Type and Date

Stakeholder Involvement Type	Date (s) for Involvement
Focus group discussions	1/14/2025, 2/11/2025, 2/28/2025, 4/8/2025, 4/25/2025, 5/13/2025, 7/25/2025, 8/29/2025, 10/14/2025, 10/17/2025, 10/31/2025, 11/18/2025
Key informant interviews with subject matter experts	7/8/2025, 7/25/2025, 10/28/2025, 10/31/2025
Public e-mail inbox submission	1/14/2025, 1/31/2025, 2/11/2025, 2/28/2025, 3/11/2025, 3/28/2025, 4/8/2025, 4/25/2025, 5/13/2025, 5/30/2025, 6/10/2025, 6/27/2025, 7/8/2025, 7/25/2025, 9/9/2025, 9/26/2025, 9/29/2025, 10/14/2025, 10/17/2025, 10/31/2025, 11/14/2025, 11/18/2025, 11/19/2025, 12/9/2025
Survey participation	1/14/2025, 1/31/2025, 3/11/2025, 4/25/2025, 7/25/2025, 8/29/2025, 9/9/2025, 9/29/2025, 10/14/2025, 10/17/2025, 10/28/2025, 10/31/2025, 11/14/2025, 11/18/2025, 11/19/2025, 12/9/2025
Training, education, and outreach related to community planning	1/14/2025, 1/31/2025, 2/11/2025, 2/28/2025, 3/11/2025, 3/28/2025, 4/8/2025, 4/25/2025, 4/25, 5/13/2025, 5/30/2025, 6/10/2025, 6/27/2025, 7/8/2025, 7/25/2025, 8/29/2025, 9/9/2025, 9/29/2025, 10/14/2025, 10/17/2025, 10/28/2025, 10/31/2025, 11/14/2025, 11/18/2025, 11/19/2025, 12/9/2025
Workgroups and committee meetings	6/10/2025, 7/8/2025, 7/25/2025, 8/29/2025, 9/9/2025, 9/29/2025, 10/14/2025, 11/19/2025, 12/9/2025

2. The following are a list of stakeholder organizations that were engaged in the planning process:

Stakeholder Organizations	
<ul style="list-style-type: none"> Avalon Carver Community Center Aviva Family and Children's Services Barbour and Floyd Medical Associates Bartz-Altadonna Community Health Center Bayfront Youth & Family Services Bayfront Youth & Family Services Behavioral Health Advisory Board Rehab (BHAB Rehab) Behavioral Health Commission- Commissioner District 5 Behavioral Health Services, Inc. (BHS) BHAB Rehab Bienestar Harm Reduction Center, East L.A. Bienestar Human Services Boys & Girls Clubs of Carson Boys & Girls Clubs of LAUSD Breaking Stigmas Treatment Operation Bridges Inc Bridges, Inc. – Community Treatment Services CA Bridge (Emergency medicine OUD treatment initiative) CA Bridge and Emergency Medicine providers and Olive View-UCLA 	<ul style="list-style-type: none"> Los Angeles County Department of Health Services Los Angeles County Department of Health Services (DHS) Los Angeles County Department of Mental Health (LACDMH) Los Angeles County Department of Mental Health (Quality Improvement Unit) Los Angeles County Department of Mental Health Outpatient Los Angeles County Department of Military and Veterans Los Angeles County Department of Public Health Los Angeles County Department of Youth Development Los Angeles County DMH PAC Los Angeles County Fire Department Los Angeles County Justice, Care and Opportunities (JCOD) Los Angeles County Library Los Angeles County Library - Woodcrest Library Los Angeles County Office of Child Protection (OCP) Los Angeles County Office of Education (LACOE) Los Angeles County Office of the Public Defender Los Angeles County Parks and Recreation Los Angeles County Probation Department Los Angeles County Public Defender Los Angeles Department of Mental Health Los Angeles Homeless Services Authority (LAHSA) Los Angeles LGBT Center

Stakeholder Organizations

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| <ul style="list-style-type: none"> • California Association of Alcohol and Drug Program Executives (CAADPE) • California Black Women's Health Project (CAWHP) • California Opioid Maintenance Providers (COMP) • California State University Long Beach • California State University, Los Angeles • Campro • Center for Integrated Family & Health Services (CIFHS) • CFGC • Child & Family Center • Child Care Resource Center • Children's Hospital Los Angeles - Community Behavioral Health • Children's Hospital Los Angeles (CHLA) • Children's Institute, Inc. • Chinatown Service Center • City of Glendale • City of Lancaster • City of Long Beach • City of Long Beach Department of Mental Health • City of Los Angeles • City of Pasadena • City of Santa Clarita • City of Santa Monica • Claremont Graduate University • Clarvida • Coach Afi G • Coalition for Responsible Community Development • Community Clinic Association of Los Angeles County (CCALAC) • Community Family Guidance Center (CFGC) • Compton Family Mental Health Clinic • CRI-Help • CTC AV & The WOW Flower Project • Dangerfield Institute of Urban Problems (DIUP) • Day One • Didi Hirsch Mental Health Services • Disability Rights California • DMH-SBCAP • Exodus Recovery Inc. • Faith Base Advocacy Council • Families Uniting Families • First 5 LA • Fred Brown's Recovery Services • Friends of the Children • Futuro Health • Girls Club LA • Grace UMC • Grandview Foundation • HAI • Hamburger Home • Healing-Informed Art Center • Healthcare in Action • Helpline Youth Counseling • Helpline Youth Counseling (HYC) • HMG LA • Homeless Health Care Los Angeles (HHCLA) • Institute for Multicultural Counseling & Educational Services (IMCES) • Inner-Development Life Coaching | <ul style="list-style-type: none"> • Los Angeles Unified School District • Los Angeles Valley College • Maryvale • Meals on Wheels West • Measure of America • Mental Health Advocacy Services • Mental Health America of Los Angeles (MHALA) • Mental Health Hook Up • Mind-1-1 • Molina Healthcare • Morris-Young Legacy House • NAMI • NAMI Greater Los Angeles County • NAMI South Bay • NAMI Westside Los Angeles • National Alliance on Mental Illness • Nuevo Amanecer Latino Children Services • Olive Support Services • Olive View-UCLA Medical Center and Emergency Medicine physicians • Pacific Asian Counseling Services (PACS) • Pacific Clinics - Asian Pacific Family Center • Para Los Niños • Parents Anonymous • PARS Equality Center • Patents Anonymous • Pax House Recovery, Pasadena and A Child's Dream Altadena • PCS Family Services • Peacemakers, Inc • Peer Self-Advocacy Program at Disability Rights California • Phoenix House of Los Angeles • Planned Parenthood Los Angeles (PPLA) • Precise Behavioral Health • Proccultural Group Counseling Services • Project Impact USA • Project Return Peer Support Network • Providence (Southern California) • Public Defender • Pueblo Y Salud • Reality Center • Roots Through Recovery • Sacred Path Indigenous Wellness Center • SALT 6 • San Fernando Valley Partnership (SFVP) • San Gabriel Pomona Regional Center • Southern California Health & Rehabilitation Program (SCHARP) • Search to Involve Pilipino Americans (SIPA) • Self-Help and Recovery Exchange (SHARE) • SHIELDS for Families • Sistah Friends • Social model recovery systems • Soul Enrichment Ministries • South Bay Children's Health Center (SBCHC) • Southern California Grantmakers • Special Service for Groups (SSG) • SRD Straightening Reins • SSG – Asian Pacific Counseling & Treatment Centers (APCTC) • SSG (Special Service for Groups) SILVER • Homeless Outreach Program Integrated Care System (SSG HOPICS) • St. John's Community Health • Star View Community Services • Stars Behavioral Health Group • Step Up • Step Up on Second • Straightening reins |
|---|--|

Stakeholder Organizations

- | | |
|---|---|
| <ul style="list-style-type: none"> • International Rescue Committee (IRC) • Joe Torre Safe At Home Foundation • Just Whole Care • Kaiser Permanente Southern California • Koreatown Youth & Community Center • L.A. CADA - Los Angeles Centers for Alcohol & Drug Abuse • L.A. Care Health Plan • Los Angeles County Department of Mental Health ARISE UsCC • Life Adjustment Team/LAT Intensive Outpatient Programs • Los Angeles Centers for Alcohol & Drug Abuse (LA CADA) • Los Angeles County DMH - PEI Admin • Los Angeles County DMH + UCLA • Los Angeles County DMH SPA 1 Administration, SALT 1 Liaison • Los Angeles County PROBATION DEPARTMENT • Los Angeles County API UsCC • Los Angeles County Board of Supervisors • Los Angeles County CEO - Budget and Operations Management Branch • Los Angeles County Chief Executive Office (CEO) • Los Angeles County Department of Children and Family Services (DCFS) • Los Angeles County Department of Education | <ul style="list-style-type: none"> • Supportive Housing Alliance (Los Angeles County) • Sycamores • Tarzana Treatment Center • TCMHA • The Joe Torre Safe At Home Foundation • The People Concern • The Sidewalk Project • The Village Family Services • The Wall Las Memorias Project • The Whole Child • Tia Chucha's Centro Cultural & Bookstore • Transform Health • Tri-City Mental Health Authority • UCLA Health - Population Behavioral Health • UMMA Community Clinic • University of Southern California Chan Division of Occupational Science and Occupational Therapy • Variety Boys & Girls Club • Wellnest – Emotional Health & Wellness • Westside Infant-Family Network (WIN) • Wherewithal Development Foundation • Wolf Connection • You Star Foundation • Youth Commission • Youth Guidance - BAM Los Angeles • Youth With A Purpose • YWCA San Gabriel Valley |
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a. **For counties with a population greater than 200,000, the following is a list of the five most populous cities in the county:**

- Los Angeles
- Long Beach
- Santa Clarita
- Glendale
- Lancaster

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

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

The Los Angeles County Behavioral Health Services Act (BHSA) Community Planning Process (CPP) was conducted through a structured, four-phase approach designed to support inclusive engagement and shared understanding and emphasizing transparency, accessibility, and continuous community participation to align local priorities with statewide behavioral health goals.

Phase 1: Foundation Building (January–March 2025) focused on establishing the structures, relationships, and shared frameworks needed to support meaningful community engagement. Participants worked collaboratively to develop a shared definition of behavioral health and an integrated behavioral health system and

also emphasized building a collective identity among participants by identifying shared values, lived experiences, and differences to be honored throughout the process. Governance frameworks—including Community Planning Team (CPT) roles and shared agreements—were finalized, and recruitment efforts were launched to recruit 160 members for the Community Planning Team (CPT), representing all the state-required stakeholder groups and the county social and cultural diversity. This phase concluded with a formal kickoff and onboarding session in late March.

Phase 2: Stakeholder Input (April–August 2025) centered on gathering broad stakeholder input across the behavioral health continuum and the statewide behavioral health goals. In April and May, participants defined and reviewed the local behavioral health continuum and identified unmet needs and service gaps across primary prevention, early intervention, outpatient and intensive outpatient services, and housing interventions. From June through August, the process shifted to statewide behavioral health goals, focused on preparing disparity data and facilitating discussions on disparities related to access to care, homelessness, justice involvement, institutionalization, child removal, untreated behavioral health needs, and engagement in schools. Stakeholder identified factors driving disparities and proposed overarching solutions. Their input was documented and shared with subject matter experts for both departments to prepare their program presentations during Phase 3.

Phase 3: Stakeholder Feedback (September–December 2025) emphasized transparency and accountability by presenting proposed BHSA and non-BHSA-funded programs, responding to stakeholder questions from Phase 2, and gathering structured feedback. Sessions were held twice a month to review programs, supplemented by additional forums on Behavioral Health Prevention, Housing Interventions, and Youth Engagement focus groups. Regular updates were also provided to the Behavioral Health Commission to ensure alignment and oversight. Altogether, representatives from over 225 organizations and department offices participated in these sessions.

Phase 4: Closing and Preparing for Implementation (January–June 2026) will focus on the formal approval of the BHSA Integrated Plan and readiness for implementation. This phase includes a BHSA Integrated Plan forum for the BHSA Community Planning Team members, followed by 30-day posting period in March, a public hearing in April, and a final approval by the Board of Supervisors in May. Capacity building sessions will also be held during these six months to prepare the BHSA CPT shift toward monitoring the implementation of the BHSA Integrated Plan.

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.

1. **Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.: Yes**
2. **Please describe how the [county engaged with LHJs, along with Medi-Cal managed care plans \(MCPs\)](#), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities:**

DPH-SAPC contributed to the LA County Department of Public Health's CHA and CHIP processes by sharing data, attending key meetings, and collaborating on surveys in the following ways:

- SAPC analyzed data for multiple indicators from 179 places in LA County. The data was included under the behavioral health theme of the Community Health Profiles (CHPs) data platform, which is the cornerstone of DPH's CHA.
- As a result of this work, the LHJ in LA County incorporated substance use questions into the LA County Health Survey. The data was featured heavily in the CHPs.
- SAPC reviewed and edited narrative text included in the CHPs about the importance of the included SUD indicators and highlighted the work SAPC is doing. Links back to SAPC were included.
- SAPC provided funding support for the LHJ for this effort and also contributed to the CHIP survey.

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

Collaboration

1. **Please select how the county collaborated with the LHJ**
 - Attended key CHA and CHIP meetings as requested.
 - Served on CHA and CHIP governance structures and/or subcommittees as requested.
 - Other: We are meeting with LA County DPH (the LHJ in LA County), Long Beach, and City of Pasadena (which have their own Public Health Departments in LA County) and the MCPs to discuss how we can be involved in future CHA/CHIP planning efforts, including sharing data and attending meetings.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

1. **The following were Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP:**

- Overdoses
- Other: We have initiated conversations with our MCPs and LHJs to discuss the statewide behavioral health goals and data sharing requirements so that we can plan for future IPs. We were not able to share data for the first IP due to timing. Specifically, we have identified and aligned on three behavioral health goals across the MCPs as part of the PHM strategy deliverable (access to care, homelessness, and untreated behavioral health conditions).

2. **Was data shared?** No

Data-Sharing from MCPS and LHJs to Support IP development

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

Other: We have initiated conversations with our MCPs and LHJs to discuss the statewide behavioral health goals and data sharing requirements so that we can plan for future IPs. We were not able to share data for the first IP due to timing. Specifically, we have identified and aligned on three behavioral health goals across the MCPs as part of the PHM strategy deliverable (access to care, homelessness, and untreated behavioral health conditions).

2. **Was data shared?** No

Stakeholder Activities

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

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

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

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

- a. Yes: We reviewed the CHA and CHIP for disparities and focus areas and have engaged our LHJs in planning discussions in align the CHA/CHIP with the statewide behavioral health goals for future Integrated Plans. Key findings are as follows and align with data and discussions with CPT members regarding disparities found in

other data sources and their own lived experiences:

- Untreated behavioral health conditions disproportionately affect Black/African American, low-income, and other marginalized groups. County data shows higher overdose and suicide mortality rates among Black/African American and low-income residents. According to the CHEIP, 58% of gender non-binary adults have depression, and suicide ideation affects 48% of gender non-binary, non-confirming, and Queer populations. There are significant disparities in suicide rates among gender non-binary, non-confirming, and Queer individuals, with 29.6% of these individuals reporting suicide attempts. Additionally, youths are hospitalized for suicide attempts at rates 2-10 times higher than older adults.
- The Los Angeles County CHEIP reveals that certain behavioral health and socioeconomic factors increasing the risk of children being removed from their homes disproportionately affect specific communities. Parental mental health, such as depression, affects 8% of caregivers overall, but affects 11% parents/caregivers in poverty. Additionally, data from Los Angeles County Health Assessments (CHA) reports 37% of families experience childcare access difficulties, with rates reaching 45% in Metro areas and low-income families.
- Crime data indicates that some communities may have disproportionate involvement with the justice system. The Community Health Assessment reports violent crime rates reached 525.9 per 100,000 countywide in predominately Black/African American, Latinx, and low-income communities in South LA (SPA 6) and Metro LA (SPA 4). The CHEIP reflects a disproportionately high homicide rate for Black/African American residents, who experience a homicide rate of 33.4 per 100,000 compared to the County rate of 8.1.
- The CHEIP reveals housing instability among LA County residents. Racial and socioeconomic disparities exist among the 524,000 LA County adults who have experienced homelessness or unstable housing in the past 5 years. Black/African Americans face the highest rates of homelessness (16%) followed by American Indian/Alaska Natives (14%), and US-born Latinx (10%). Gender disparities also exist with 36% of transgender females and 16% of gender non-binary individuals experiencing housing instability. Adults with disabilities report 11% homelessness versus 5% without disabilities. Geographic disparities also differ with 13% in SPA 1 (Antelope Valley) compared to 3% in SPA 5 (West).
- According to the LA county Community Health Equity Improvement Plan (CHEIP) 25% of adults reported difficulty accessing needed medical care, and 21% reported not having a regular source of health care. Furthermore, 49% of gender non-binary individuals, 37% of Latinx, and 33% of individuals with disabilities struggle to access care. The CHEIP utilized data from several data sources including, the Community Health Profiles, the LA County Health Survey, and program specific data.
- The pregnancy related mortality ratio (PRMR) reported in the CHEIP also indicates disparities in access to care, as the PRMR for Black/African American mothers is over 3 times that of White mothers and remains consistently higher than other racial/ethnic groups.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to [B.2 Considerations of Other Local Program Planning Processes](#).

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

DPH-SAPC and DMH initiated conversations with LA Care, Health Net, and Kaiser Permanente about their community reinvestment planning efforts starting October 2025 and continue to engage in meetings to discuss and align areas of shared focus, such as three behavioral health goals that were identified under the PHM strategy deliverable. Both DPH-SAPC and DMH shared their strategies, programs, and gaps under the identified behavioral health goals to inform MCP planning efforts.

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

As of October 2025, the Los Angeles County Department of Mental Health and the Department of Public Health – Substance Abuse and Prevention Control are engaging with MCPs to discuss goals and explore collaboration on the community investment plan. We are at the early stages of these conversations.

MCP reinvestment planning is ongoing and we expect to have more details in Q1 of 2026.

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Comment Period and Public Hearing

For related policy information, refer to [B.3 Public Comment and Updates to the Integrated Plan](#).

1. **Date the draft Integrated Plan (IP) was released for stakeholder comment:** 02/11/2026
2. **Date the stakeholder comment period closed:** 03/13/2026
3. **Date of behavioral health board public hearing on draft IP:** 04/09/2026
 - a. Please provide proof of a public posting with information on the public hearing:
See Attachment #A
4. **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:**
[BHSA Announcements - Department of Mental Health](#)
5. **Please select the process by which the draft plan was circulated to**
6. **stakeholders**
 - Public posting
 - Email outreach, see Attachment #B
7. **Please specify the other process the draft plan was circulated to stakeholders:** N/A
8. **Please describe [stakeholder input](#) in the table below. Please add each stakeholder group into their own row in the table**

Table 3. Stakeholder Input:

Feedback received during public comment period	
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Health care organizations, including hospitals; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita) Other: California Association of Alcohol and Drug Program Executives (CAADPE)
Summarize the substantive revisions recommended this stakeholder during the comment period	<ol style="list-style-type: none"> 1. Embed SUD language in every section that currently references “behavioral health” but only describes mental health service: Add explicit references to SUD needs, SUD service pathways, and co-occurring disorder considerations in the County Behavioral Health System Overview, Care Transitions, and Statewide Behavioral Health Goals sections. This ensures parity and avoids reinforcing the mental health only framing that appears throughout the draft. 2. Expand the “Populations Served” section to include deeper SUD specific demographic Insights: The draft provides detailed mental health penetration disparities but minimal SUD specific disparities. Add SUD prevalence, unmet need, overdose trends, and demographic disparities to match the depth of mental health analysis. 3. Strengthen the Care Transitions section by explicitly describing SUD specific- transition Pathways. Include transitions from: <ul style="list-style-type: none"> • Withdrawal management → residential → outpatient • ED → MAT initiation → community follow-up • Jail/prison → community SUD care. The current section is almost entirely mental health focused.

Feedback received during public comment period

4. Add SUD integration requirements to all crisis-related program descriptions. Crisis Residential, PMRT, UCCs, and CRTPs are described only in mental health terms. Add: SUD screening in crisis settings, MAT initiation and Harm reduction services and Warm handoffs to DMC-ODS providers

5. Strengthen the Workforce Strategy by explicitly addressing SUD workforce shortages. The draft focuses heavily on mental health workforce development. Add: SUD counselor pipeline expansion, MAT prescriber recruitment, cross-training for co-occurring disorders and Integration of SUD competencies into all clinical and peer training.

6. Integrate SUD considerations into all housing and homelessness: The Housing Interventions section currently emphasizes mental health. Add:

- Low barrier- SUD services in interim and permanent supportive housing
- Field based- SUD teams embedded in homeless outreach
- MAT access in shelters and encampments
- Harm reduction supply distribution

7. Require co-occurring disorder capability across all programs described in the plan: Many programs (e.g., Clubhouses, Day Treatment, Peer Respite, CFRCs) are described as mental health-only. Add a requirement that all programs: screen for SUD, provide brief interventions, offer warm handoffs to SUD treatment, and train staff in co-occurring disorder competencies

8. Add SUD specific performance measures to the -County Selected- Goals and Statewide Goals sections. The plan currently includes detailed mental health metrics, but few SUD metrics. Add measures such as:

- MAT initiation and retention
- SUD treatment penetration
- Overdose mortality and non-fatal overdose rates
- Youth SUD engagement and retention

o Co-occurring disorder treatment rates

9. Strengthen the description of SUD prevention and early intervention: Prevention is mentioned but not integrated into the broader system narrative. Add:

- Youth SUD prevention strategies
- School based- SUD screening
- Community level- prevention partnerships
- Overdose prevention education in all BHSS programs

10. Ensure every program narrative includes a clear SUD component. For each major program category (e.g., FSP, crisis services, youth programs, community partnerships), add: How SUD services are incorporated, How co-occurring needs are addressed, How SUD outcomes will be measured and How SUD providers will collaborate with DMH programs. This creates a consistent, integrated behavioral health narrative rather than a mental health dominant one.

Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Health care organizations, including hospitals; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita) Other: California Association of Alcohol and Drug
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Feedback received during public comment period	
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Program Executives (CAADPE)</p> <p>Recommendations for Integrating Primary Care</p> <p>1. Embed primary care integration into the “County Behavioral Health System Overview.” Add a subsection describing how primary care settings serve as behavioral health access points. Include language on co-location, warm handoffs, and shared care models between DMH, SAPC, and primary care clinics. This ensures primary care is framed as part of the core behavioral health ecosystem, not an external partner.</p> <p>2. Strengthen the “Care Transitions” section by adding primary care- -specific pathways.</p> <p>Describe transitions such as:</p> <ul style="list-style-type: none"> • ED → primary care follow-up for behavioral health needs • SUD or MH discharge → primary care for chronic disease management • Primary care → specialty behavioral health via standardized screening <p>This aligns with the state’s emphasis on whole person- care and closes a major gap in the current draft.</p> <p>3. Add primary care integration requirements to the “Service Delivery Landscape.” Include primary care as a formal service setting where:</p> <ul style="list-style-type: none"> • SUD screening (SBIRT) occurs • MAT can be initiated • Depression, anxiety, and SUD brief interventions are delivered <p>This section currently lists many programs but does not explicitly include primary care as a behavioral health delivery site.</p> <p>4. Integrate primary care roles into the “Statewide Behavioral Health Goals” and performance measures. Add metrics such as:</p> <ul style="list-style-type: none"> o Percent of primary care clinics conducting behavioral health screenings • MAT initiation in primary care • Warm handoffs from primary care to DMH/SAPC <p>This ensures primary care is not only mentioned but measured and accountable.</p> <p>5. Add primary care partnerships to the “Workforce Strategy” section. Include strategies to:</p> <ul style="list-style-type: none"> • Train primary care providers in behavioral health competencies • Expand integrated care teams (CHWs, peers, SUD counselors) in primary care • Support cross training- between DMH/SAPC and primary care networks. <p>This section currently focuses heavily on mental health workforce needs; adding primary care strengthens whole person's- care alignment.</p>
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents; Women Centered Trauma Informed Care Services
Summarize the substantive revisions recommended this stakeholder during the comment period	The stakeholder is emphasizing the need for the County to prioritize equity and accessibility by creating transparent pathways for small, community-based organizations to enter and grow within the Medi-Cal behavioral health system. There is a strong call to

Feedback received during public comment period	
	<p>move beyond established contractors by pairing workforce development with targeted technical assistance in areas like billing, compliance, and recruitment. By providing specific support such as loan repayment and tuition assistance for smaller nonprofits, the County can ensure that capacity-building efforts reach neighborhood-rooted providers who are often best positioned to serve those "closest to the ground."</p> <p>Furthermore, the feedback highlights a necessity for better integration of co-occurring (mental health and substance use) care and stronger alignment between residential settings, community-based day programs, and housing. Stakeholders are looking for clear, publicly reported benchmarks to track the effectiveness of BHSA investments in reducing institutionalization, particularly for older adults. To achieve this, they recommend leveraging the Prudent Reserve for innovation and ensuring that BHSA funds are seamlessly coordinated with CalAIM and other funding streams to create a unified, non-fragmented system of care.</p>
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); Health care service plans, including Medi-Cal Managed Care Plans (MCPs); Community-based organizations serving culturally and linguistically diverse constituents; CRTP
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are seeking clear guidance and enhanced support for Crisis Residential Treatment Programs (CRTPs) to prepare for the evolving continuum of care, specifically requesting more frequent feedback from the Department of Mental Health. Key recommendations include increasing the current 16-bed capacity limit, providing additional funding for facility expansion, and delivering better training on CRTP guidelines and clinical interventions to improve stabilization rates.
Stakeholder group that provided feedback	Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Community-based organizations serving culturally and linguistically diverse constituents
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Stakeholders are urging the County to address a critical mortality crisis among Asian and Pacific Islander (API) youth, for whom suicide is the #1 leading cause of death in Los Angeles County, outranking both homicides and motor vehicle accidents. The feedback highlights a lethal "Mortality-Utilization Gap," noting that while API students show high "Engagement in School," this academic success often masks severe distress. Despite having the highest suicide risk, this group has a staggering 0.28 service utilization rate, the lowest in the County. To address this, the suggestion is to shift away from broad "BIPOC" categories and fund "Selective Prevention" strategies that specifically target the unique cultural drivers of ideation within the API community.</p> <p>To bridge this gap, the stakeholder recommends allocating the 4% Population-Based Prevention budget using a formula weighted by mortality-to-utilization ratios rather than universal distribution. They propose funding Community-Defined Evidence Practices (CDEPs)</p>

Feedback received during public comment period	
	<p>in trusted spaces like cultural centers and schools to reach "non-system involved" youth who fall outside traditional Medi-Cal eligibility. Additionally, the plan calls for a specialized Suicide Prevention Pipeline to recruit API providers trained to navigate the "Model Minority" pressure and intergenerational stigma. By focusing on these "hidden" high-risk groups, the County can proactively reach youth who are currently dying at disproportionate rates before they ever enter a formal clinical facility.</p>
Stakeholder group that provided feedback	<p>Providers of mental health services and substance use disorder treatment services; Continuums of care, including representatives from the homeless service provider community</p>
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Recovery residences should be explicitly recognized within statewide goal implementation strategies as structured stabilization environments for individuals with:</p> <ul style="list-style-type: none"> • Serious mental illness (SMI) • Co-occurring substance use disorders • Frequent emergency department utilization • Repeated psychiatric hospitalization • Justice system involvement • Housing instability or homelessness <p>Recovery housing can support statewide goals by functioning as:</p> <ul style="list-style-type: none"> • Step-down from inpatient psychiatric hospitalization • Step-down from residential SUD treatment • Diversion alternative to higher-cost crisis settings • Reentry stabilization following incarceration • Structured transition from homelessness to permanent housing <p>In addition, recovery residences should be considered part of the County's equity strategy. Structured recovery housing models can prioritize access for disproportionately impacted communities, justice-involved individuals, and chronically unhoused populations who experience elevated behavioral health disparities.</p> <p>Incorporating culturally responsive programming within residential stabilization settings supports statewide goals related to health equity, access, and long-term recovery outcomes.</p> <p>Structured recovery housing may also function as a preventative intervention by reducing relapse, psychiatric decompensation, and re-hospitalization, supporting long-term system stabilization and cost avoidance.</p> <p>Clarification and strengthening of the following areas would improve implementation:</p> <ol style="list-style-type: none"> 1. Recognition of Recovery Residences Under Housing Interventions: Licensed or certified sober living recovery residences should be explicitly identified as eligible housing intervention partners. Recovery housing provides structured stabilization and should not be viewed solely as general housing. Funding eligibility should include operating subsidies, staffing support for peer recovery services, and capital improvements to increase bed capacity. 2. Integrated Service Model Recognition: Recovery residences operating under a BHSA-aligned framework may incorporate: <ul style="list-style-type: none"> • Individualized care plans • Time-bound recovery goals • Case management and care coordination • Peer recovery support • Medication management coordination • Clinical oversight (as appropriate)

Feedback received during public comment period

- Structured programming
- Warm handoffs to outpatient behavioral health services

Recognizing this integrated model allows recovery housing to function as part of the behavioral health continuum rather than solely as a housing intervention.

3. Full Service Partnership (FSP) Alignment; Recovery residences may function in coordination with or as structured extensions of Full Service Partnership (FSP) models for individuals requiring residential stabilization. Integrating recovery housing into FSP care plans can support individuals who need structured environments while maintaining community-based service alignment.

4. Crisis System Integration: Recovery residences may serve as post-crisis stabilization environments aligned with the County's broader crisis response system, including 988 response pathways, crisis stabilization units, psychiatric emergency services, and CARE Court placements. Recognizing recovery housing as part of crisis diversion and step-down infrastructure strengthens the behavioral health continuum and reduces reliance on higher-cost acute settings.

5. Braided and Bundled Funding Flexibility: The Integrated Plan should allow for braided and bundled funding models combining housing operating support with behavioral health service delivery. This enables comprehensive stabilization services within a coordinated framework and reduces system fragmentation.

6. Formal Partnerships: Structured referral pathways and contractual partnerships between County behavioral health programs and certified recovery residences should be encouraged to ensure coordinated care transitions from hospitals, treatment facilities, crisis systems, and carceral settings.

BHSA workforce investments should explicitly be available to residential recovery settings, including:

- Peer workforce pipeline development
- Training stipends
- Clinical supervision support
- Retention incentives
- Ongoing professional development

Supporting workforce development within residential stabilization settings strengthens system capacity, improves service quality, and aligns with statewide workforce expansion goals.

Recovery residences serving high-acuity populations should also be incorporated into County data collection and performance reporting systems. Participation in outcome tracking, utilization monitoring, and quality reporting ensures transparency and strengthens the County's ability to measure the impact of residential stabilization models within the broader behavioral health network.

The Budget and Expenditure sections would benefit from additional clarity regarding:

- Allocation of Housing Intervention funds
- Capital vs. operating funding structures
- Eligibility for service-integrated residential models
- Multi-year operating commitments for high-acuity stabilization settings
- Capital Expansion

BHSA housing funds should support:

- Acquisition of residential properties
- Rehabilitation and code compliance
- ADA accessibility improvements

Feedback received during public comment period	
	<ul style="list-style-type: none"> • Safety and security upgrades <p>Capital investment pathways will enable scalable bed expansion while maintaining quality and regulatory compliance.</p> <p>Multi-Year Operating Stability</p> <p>Multi-year operating commitments enable responsible scaling, workforce retention, and infrastructure investment.</p> <p>To ensure sustainable system integration, the County should consider how recovery residences may participate in future funding opportunities, Requests for Proposals (RFPs), and implementation guidance tied to housing and stabilization services. Structured stakeholder engagement with certified recovery residence providers during future funding design will improve program effectiveness and operational feasibility.</p>
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); Providers of mental health services and substance use disorder treatment services; Veterans
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are calling for expanded resources and clearer guidelines to improve coordination between mental health agencies and law enforcement, ensuring reliable hospital transportation for individuals under LPS holds across all programs, including AB109.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Continuums of care, including representatives from the homeless service provider community; Community-based organizations serving culturally and linguistically diverse constituents; Peer Run Agency and Peer Run Programs
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are concerned that requiring nonprofit, peer-run agencies operating under Community Outreach Services (COS) funding to transition to Medi-Cal models could negatively impact service delivery and undermine the unique value of the peer-run approach.
Stakeholder group that provided feedback	Eligible adults and older adults (individuals with lived experience); One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Regional centers; SA-8, SALT-8
Summarize the substantive revisions recommended this stakeholder during the comment period	Stakeholders are calling for the establishment of a dedicated funding stream to serve individuals who fall outside of strict "priority population" definitions, ensuring the BHS Final Plan remains inclusive. Additionally, they advocate for the use of Outreach and Engagement (O&E) funds to support client enrichment, emphasizing that enhancing quality of life is a fundamental pillar of mental health care.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Health care organizations, including hospitals; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita)

Feedback received during public comment period	
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>In regards the Statewide Population Behavioral Health Goals:</p> <ul style="list-style-type: none"> • Add explicit SUD strategies within statewide goals (homelessness, justice involvement, school engagement). • Prioritize harm reduction/low-barrier care, overdose prevention, and MAT/diversion pathways. • Add SUD performance measures (MAT initiation/retention, treatment penetration, overdose outcomes, youth engagement, co-occurring treatment rates). • Expand SUD data/disparities analysis and strengthen co-occurring disorder discussion. • Use “behavioral health” consistently to mean both mental health and SUD (parity). <p>In regards to Behavioral Health Services Act/Fund Programs:</p> <ul style="list-style-type: none"> • Rebalance the BHSA plan so SUD are co-equal with mental health throughout. • Clarify DMH–SAPC integration (shared governance, planning, data, QI, unified metrics). • Expand SAPC/SUD program descriptions to match mental health detail (capacity, MAT, field-based care, etc.). • Build SUD into crisis/housing/care transitions (screening, MAT initiation, harm reduction, warm handoffs). • Require co-occurring capability and strengthen whole-person integration by embedding primary care in BH settings. <p>In regards to Workforce Strategy:</p> <ul style="list-style-type: none"> o Address parity: specify SUD workforce challenges alongside mental health. <ul style="list-style-type: none"> • Add SUD workforce strategies (pipeline/certification, recruitment/retention, harm reduction staffing, peers). • Expand MAT prescriber capacity and readiness across settings. • Resource cross-training for co-occurring disorders across roles. o Add primary care partnerships to support integrated teams.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Local public health jurisdictions; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Continuums of care, including representatives from the homeless service provider community
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Stakeholders have expressed significant concern that the Integrated Plan lacks a universal data collection mechanism, making the current behavioral health goals and baselines appear inaccurate. Without a concrete plan to rectify data silos or integrate sharing across systems of care—including the often-fragmented coordination between LACDMH, SAPC, and local Continuum of Care providers—true accountability and transparency remain out of reach. The feedback emphasizes that valid outcome measurement is impossible without first building a foundational infrastructure for tracking progress across the County’s vast geographical and departmental landscapes.</p> <p>Furthermore, the draft is criticized for failing to provide a clear blueprint for how the County will actually integrate services, particularly regarding the massive allocation of BHSA housing funds. Despite the creation of the new Homeless Services and</p>

Feedback received during public comment period	
	<p>Housing Department, there is a lack of detail on how systems will reduce duplication of services, maximize funding efficiency, or align with local health assessment processes. Stakeholders argue that for a county as complex as Los Angeles, the plan must move beyond separate departmental responses and establish a unified strategy for cross-system collaboration to support vulnerable populations who move between jurisdictions and service providers.</p>
Stakeholder group that provided feedback	<p>Eligible adults and older adults (individuals with lived experience); Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita)</p>
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>The International Rescue Committee (IRC) - Los Angeles urges the County to explicitly include "newcomers" and forcibly displaced individuals as a target population within the BHSA, noting that up to 90% of young newcomers face unaddressed trauma and significant barriers to care. The stakeholder highlights that current strategies are overly reactive, focusing on crisis response while neglecting primary prevention and mental health literacy for those not yet in dire need. To address this, they recommend reallocating funds toward "solution-oriented" programming—such as trauma-informed case management, financial coaching, and housing navigation—that tackles the underlying stressors of displacement rather than simply providing referrals to overcapacity external systems.</p> <p>Furthermore, the IRC advocates for a shift from basic cultural sensitivity to true cultural responsiveness, integrating gender-specific strategies and diverse household structures into service delivery. They emphasize that workforce development must move beyond technical training to equip staff with the tools to navigate immigration backgrounds, language barriers, and documentation hurdles. By leveraging the expertise of deeply embedded partners like the IRC, the County can build a specialized workforce of housing and employment specialists who provide the practical, culturally resonant support necessary to foster long-term self-sufficiency and prevent the deterioration of mental health among Los Angeles's newest residents.</p>
Stakeholder group that provided feedback	<p>Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents</p>
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Stakeholder is urging the inclusion of Managing and Adapting Practices (MAP) in the list of approved Evidence-Based Practices, noting that their established train-the-trainer model allows for sustainable, in-house implementation despite the loss of PEI training funds. Beyond specific programming, there is significant concern that the Integrated Plan serves more as a regulatory requirement than a functional roadmap, as it lacks critical details on the strategy, timing, and methodology for realigning services. Providers are calling for greater transparency regarding operational data points—such as caseload expectations and budget impacts—to allow for effective implementation planning and a clearer understanding of how the County will bridge current system gaps.</p>

Feedback received during public comment period	
Stakeholder group that provided feedback	Early childhood organizations, First 5 County Commission
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>First 5 LA is urging the County to ensure that the unique needs of families with young children and pregnant individuals are not overshadowed by the focus on individual adults within the BHSA housing and homelessness strategies. Citing research that links housing insecurity to higher rates of maternal morbidity and preterm births, the stakeholder advocates for prioritizing families in program eligibility and shoring up housing supports specifically designed for those with infants and toddlers. They emphasize that while the plan acknowledges systemic disparities, it must go further by disaggregating "Asian" and "Pacific Islander" data to reveal distinct outcomes and by explicitly defining how each goal area will address the root causes of systemic racism.</p> <p>Regarding the workforce and early intervention, stakeholders are calling for a more coordinated, prenatal-to-five mental health approach that prevents the developmental needs of the youngest children from being diluted within broad 0–25 initiatives. They recommend a targeted workforce strategy to increase cultural and linguistic representation, suggesting models like the Parental Perinatal Mental Health e-consultation to extend specialized expertise to community sites. Finally, First 5 LA requests transparent funding breakdowns and a direct comparison to prior MHSA allocations to ensure that the shift to BHSA does not result in an unintended reduction of resources or service disruptions for the County's most vulnerable young children and their caregivers.</p>
Stakeholder group that provided feedback	Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Youths (individuals with lived experience) or youth mental health or substance use disorder organizations
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>The California Black Women's Health Project expresses profound disappointment with the Integrated Plan, highlighting a troubling "escalation gap" where Black residents are overrepresented in severe mental health services but underrepresented in mild-to-moderate care. This disparity indicates a systemic failure in prevention; Black community members often only enter the system once their needs have reached a crisis level due to structural barriers and a lack of early outreach. The stakeholder argues that the plan's failure to account for socioeconomic realities—such as disproportionately high rates of unemployment, housing instability, and incarceration—results in an incomplete understanding of community needs and misaligned resource allocation.</p> <p>To achieve true equity, the stakeholder demands the explicit inclusion of Community-Defined Evidence Practices (CDEPs), which leverage lived experience and cultural wisdom to build trust in marginalized communities. They also criticize the current budget allocation, noting that funding for Substance Use Disorder (SUD) services disproportionately outweighs mental health funding despite higher utilization rates for the latter. The feedback calls for a total revision of the plan to prioritize early intervention for Black communities, integrate structural determinants of health into all assessments, and rebalance funding to reflect actual service demand and population needs.</p>
Stakeholder group that provided	Community-based organizations serving culturally and linguistically

Feedback received during public comment period	
feedback	diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Eligible adults and older adults (individuals with lived experience); Early childhood organizations
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Stakeholders are raising urgent questions regarding the transition from MHSA to BHSA, specifically seeking clarity on how existing services for parents, children, and youth will be protected. There is a notable concern over the lack of transparency regarding the "quantity of recipients" who may lose access to care and which community-based organizations (CBOs) will be impacted. Feedback highlights that while the plan identifies ambitious statewide goals, it fails to provide the data used to select specific programs or a roadmap for how the 51% of Early Intervention funds mandated for youth will be distributed beyond "legacy" contractors. Without structured data on capacity-building pathways, stakeholders fear the system will remain limited to large, established providers, excluding the smaller, grassroots, and minority-led organizations that often hold the most community trust.</p> <p>To bridge these gaps, stakeholders recommend a dedicated infrastructure and technical assistance strategy to help smaller providers navigate fiscal modeling, claims readiness, and CalAIM-aligned workflows. There is also a call for a more realistic workforce strategy that addresses the 20% vacancy rate and explicitly supports non-licensed roles—such as parent partners, doulas, and "credible messengers"—who are essential for upstream engagement. Furthermore, providers are seeking a "plain-language" budget narrative to explain the allocation of \$900 million in unspent funds and a clear plan to improve the 22% Managed Care Plan contracting rate among BHSA providers. By aligning community reinvestment dollars with these goals and providing specialized technical assistance, the County can ensure a sustainable, inclusive, and financially viable behavioral health ecosystem for underserved families.</p>
Stakeholder group that provided feedback	Community-based organizations serving culturally and linguistically diverse constituents; One of the five most populous cities in the county (i.e., Glendale, Lancaster, Long Beach, Los Angeles, or Santa Clarita); Providers of substance use prevention services
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Stakeholders with decades of experience in high-need areas like Skid Row are expressing concern that the shift of prevention programming to the state may undermine effective local, population-based efforts. While the state-level language emphasizes social connection and equity, the local Integrated Plan lacks clear pathways for sustaining established substance use prevention initiatives. The feedback highlights that strong relational ties and community-based prevention are foundational to reducing addiction risk and building long-term stability, yet these "upstream" strategies feel less explicit in the current County roadmap compared to clinical interventions.</p> <p>To rectify this, stakeholders are calling for prevention to be recognized as a permanent, core component of the behavioral health spectrum with an equitable share of resources. They specifically point out that the current 4% minimum allocation for population-based prevention is extremely low given its cost-effectiveness and reach. Recommendations include making multi-year investments to protect prevention during budget transitions, integrating lived experience to dismantle systemic racism, and</p>

Feedback received during public comment period	
	utilizing community-defined evidence practices to meet vulnerable populations where they are. The goal is to move beyond crisis management and toward a system that builds community resilience through radical connection and civic engagement.
Stakeholder group that provided feedback	Providers of mental health services and substance use disorder treatment services; Local public health jurisdictions; Community-based organizations serving culturally and linguistically diverse constituents; Health care organizations, including hospitals
Summarize the substantive revisions recommended this stakeholder during the comment period	<p>Stakeholders are calling for the BHSA Integrated Plan to move beyond broad geographic goals and prioritize authentic, neighborhood-level investment in high-need Latinx communities such as East LA, South LA, and South Central. There is a strong emphasis on funding nurse-led and community health worker (CHW) models—specifically promotoras—as frontline strategies rather than secondary outreach tools. Critics point out that while Latinx residents are severely underrepresented in specialty mental health services, the current plan relies heavily on licensed clinical roles within the County system, effectively overlooking the bilingual, community-rooted workforce that already serves as a trusted bridge to care for those skeptical of formal institutions.</p> <p>To ensure accountability, stakeholders demand that the County provide disaggregated outcome data by Service Planning Area (SPA), language, and ethnicity to track whether service gaps are actually narrowing. They also urge the creation of a "plain-language" budget summary in both English and Spanish, arguing that the current jargon-heavy documentation creates a health literacy barrier that excludes the public from meaningful engagement. Recommendations include establishing a dedicated subcontracting pipeline for small, BIPOC-led organizations and setting a "community reinvestment floor" to ensure a defined percentage of funds reaches grassroots providers who are already culturally and linguistically embedded in underserved neighborhoods.</p>

- 9.
9. **Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update.**

Clinical and Service: The Behavioral Health Commission (Commission) strongly advocates prioritizing early intervention in childhood mental health, particularly for children ages 0–5. It emphasizes that proactive consultation at the preschool level can prevent more severe issues in adolescence and adulthood. Regarding LGBTQ+ youth — with particular attention to transgender, gender diverse, and intersex (TGI) young people — the Commission urges concrete measures to ensure authentic access to gender-affirming hormone therapy, surgical navigation support, and care that is authentically affirming, trauma-informed, and culturally sensitive, moving beyond policy declarations toward comprehensive, system-wide implementation. The Commission recommends that the County protect and fund community-defined outreach pathways for Transitional-Aged Youth (TAY) to bridge the barriers they face in engaging with early interventions.

The need for extensive training in withdrawal management for all therapists was also emphasized, addressing a deficiency in specialized care often missing from standard clinical education. The Commission recommends specifying which clinician categories are covered,

what certification or competency standard applies, the funding source, and a reporting mechanism for training completion.

To enhance stabilization and minimize barriers to care, the Commission recommends eliminating intake restrictions on weekends and Fridays and promoting better integration so that SAPC and LACDMH facilities can mutually enhance their nursing and stabilization capabilities. Furthermore, the importance of monitoring and supporting underserved populations, including Black men, men in their late 20s to 40s, older adult women, non-English speakers, TGI individuals, and seniors, was highlighted, with a recommendation to establish dedicated services for these high-risk groups and for DMH and SAPC to report service utilization, engagement, and outcome data, disaggregated by these demographics, on a recurring basis. Lastly, the Commission recommends the use of community-defined evidence practice on par with evidence-based practice and the need for a Behavioral Health Unit for minors that serves the San Fernando, Santa Clarita, and Antelope Valleys.

Bureaucracy: The Commission's recommendations on bureaucracy focus on making it easier for smaller Community-Based Organizations (CBOs) and grassroots groups to participate. To achieve this, the Commission recommends establishing clear steps and providing technical support so these organizations can navigate complex county insurance and approval rules. Simplifying these processes aims to encourage more groups to provide services and increase the number of providers in the system.

Workforce: The Commission's workforce recommendations aim to support and recognize skilled clinicians and peers in the behavioral health system. The Commission recommends establishing Advanced Level Practitioner (ALP) classifications, also known as "career ladders," so expert therapists can earn higher pay for their clinical skills without moving into administrative roles. The recommendations also focus on DMH and SAPC helping peer professionals with certification and renewal and on ensuring they receive a living wage, recognizing their importance to care delivery, and should include recruitment pathways for bilingual and culturally concordant clinicians, structured supervision hours for associate-level staff, and peer specialist advancement tracks tied to the living-wage recommendations in this letter.

Housing and Infrastructure: To address the housing subsidy crisis, the Commission identifies the urgent need for a clear transition plan, including timelines, identified replacement resources, and client-level contingency protocols, to support the estimated 200+ clients at risk of losing housing when Emergency Housing Vouchers (EHV) expire by year's end. The Commission also recommends appointing an Inspector General to oversee billions allocated to housing development, ensuring accountability and preventing cost overruns or misuse of funds. In response to the closure of acute inpatient beds at facilities such as Martin Luther King Hospital and UCLA Resnick, the Commission expresses concern about increased pressure on psychiatric emergency rooms and urges departments to address the growing gap in inpatient care.

With regard to Adult Residential Facilities (ARFs) in California, the Commission recommends an improved rate for licensed ARFs to support ARFs and to encourage and incentivize their expansion.

Additionally, the Commission requests that LACDMH provide regular updates on issues and opportunities as they arise throughout the BHS implementation.

Community-Centered Behavioral Health Planning: The Commission issues the following recommendations to strengthen behavioral health planning and service delivery. First, the Commission urges that all major decisions, such as the closure of Martin Luther King beds, include comprehensive community input and transparency, as a lack of engagement has contributed to service gaps and left vulnerable patients without timely care. The Commission strongly advises against reducing high-acuity inpatient psychiatric beds, which are essential and cannot be replaced by lower levels of care without jeopardizing patient safety and increasing strain on emergency departments. The Commission recommends that a Beilenson hearing be held as part of the formal process and that robust participation from public safety personnel, including police, and from psychiatric emergency, hospital, urgent care, and substance abuse providers be integrated into planning efforts. Their involvement is particularly important as new mandates expand service demands. Finally, the Commission calls for ongoing efforts to integrate behavioral health and substance abuse services, including a review and revision of regulatory requirements, to achieve comprehensive, community-responsive care.

Access and Participation: The Commission recommends that all DMH stakeholder groups review opportunities to support broader participation, including providing hybrid (in-person and virtual) meeting options, moving meeting locations and times, and redefine their purpose to align with the integration of Behavioral Health Services in Los Angeles County.

Fiscal Accountability and Outcomes: To promote fiscal responsibility and improve outcomes, the Commission recommends more closely aligning funding allocations with state-mandated objectives to mitigate the recurring problem of substantial unspent funds at the end of three-year cycles. The Commission also strongly advocates that LACMH optimize federal matching opportunities, such as Medicaid Administrative Activities (MAA), thereby freeing funds for BHSA to support direct services. The Commission recommends that DMH and SAPC report how these benefits will be distributed across directly operated clinics, contract providers, community-based organizations, and other legal entities. The Commission expresses concern about the current low percentage of the budget allocated to SAPC, which is only 2%, and recommends increasing this investment to more effectively address the needs of the substance use disorder population.

In addition, the Commission requests regular, transparent updates from LACDMH and SAPC on financial performance tied to outcomes, ideally quarterly or semiannually, including detailed variance reports comparing budgeted and actual expenditures. This practice would enhance accountability, ensure resources are fully utilized as intended, and provide transparency to the public. Regular reporting would also support the county's outcomes-based budgeting mandate and maximize the impact of allocated funds.

County Behavioral Health Services Care Continuum

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

County Provider Monitoring and Oversight

Cities submitting their Integrated Plan independently from their counties do not have to complete the Medi-Cal Quality Improvement Plan questions or Question 1 under All BHSA Provider Locations. Otherwise, all fields must be completed unless marked as optional. For related policy information, refer to [6.C.2 Securing Medi-Cal Payment](#).

Medi-Cal Quality Improvement Plans

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

See Attachment #C

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

a. See Attachment #C for the county's current QIP for SFY 2026-2027

Contracted BHSA Provider Locations

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

Table 4. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	766
Substance Use Disorder (SUD) services only	168
Both MH and SUD services	0

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

Table 5. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	624
DMC/DMC-ODS only	168
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to [B.2 Considerations of Other Local Program Planning Processes](#).

- 1. Among the county’s BHSA-funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS? 22%**

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

Through the Program Improvements for Valued Outpatient (PIVOT) project, LACDMH has an opportunity to engage providers about available opportunities, with Managed Care Plans, (MCPs) invited to participate. LACDMH is committed to expanding the number of providers delivering services tailored to our racially and ethnically diverse populations, and the diversity of our provider network strengthens our ability to meet clients’ needs. LACDMH will also continue to engage its providers in our recurring provider meetings to encourage contracting with the MCPs for NSMHS and will survey a sample of our high-volume providers to learn what it would take for them to contract with the MCPs.

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

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

- 3. Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county’s BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a**

monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

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

- a. **Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements): Yes**
- b. **Do not participate in the county's Medi-Cal Behavioral Health Delivery System?:Yes**

DRAFT

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

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

General

1. The following Behavioral Health Services and Supports (BHSS) are included in the plan:

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

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

Program #1: Outpatient Care Services

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.

1. **Please select the service type provided under Program One:** Mental health services
2. **Please describe the specific services provided:**

Outpatient Care Services (OCS) provides a broad, integrated array of clinic based, community-based (i.e. schools, residential settings), and field-based services as clinically appropriate within a recovery-focused system of care. This service is part of the mental health continuum and serves adults and older adults, who have mental health needs and co-occurring substance abuse needs, delivering mental health services that may include evidence-based or community-defined evidence-based practice and supports in a timely manner and in the most appropriate setting to meet each client's needs. Training and equipment are essential to support these evidence-based practices.

OCS is inclusive and culturally sensitive, offering linguistically appropriate services to meet the diverse communities of Los Angeles County. OCS aims to meet clients where they are, engaging them in services and guiding them toward recovery and self-determined, meaningful goals that promote connectedness, mental and physical wellbeing, and purposeful use of time. Core services include crisis stabilization, assessments, individual and/or group therapy, crisis intervention, case management, employment support, peer support, co-occurring disorders treatment, MSS, and MAT. The intensity, location (community/field or office/clinic), and duration of services are tailored to each client's needs and may change over time. While many clients move from more intensive to less intensive services, some may require extended higher-intensity supports due to factors such as higher acuity needs, treatment non-adherence, substance use, trauma exposure, or external stressors (housing, employment, relationships, or legal issues). The primary goal is engaged, active participation in the treatment journey toward recovery.

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

Table 6. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	117,925
FY 2027 – 2028	119,104
FY 2028 – 2029	120,295

- 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**

Included individuals projected to be served in outpatient. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

Program #2: Mobile Crisis Response

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.

- Please select the service type provided under Program One:** Mental health services
- Please describe the specific services provided:** Services are delivered by LACDMH clinicians who evaluate individuals at risk of self-harm, harm to others, or inability to meet basic needs; triage and de-escalation in the community; and coordination and dispatch of response teams to avoid hospitalization, incarceration, or injury. The approach emphasizes caring, trauma-informed intervention and strives to reduce stigma while supporting clients and families.
- Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below**

Table 7. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	12,968
FY 2027 – 2028	13,097
FY 2028 – 2029	13,227

- 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**

Included individuals served by Mobile Crisis Response. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

Early Intervention Program:

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

1. Program or service name #1: Children and Youth Wellbeing Services (CYWS)

The Children and Youth Wellbeing Services (CYWS) program provides targeted, comprehensive care for children, youth, and TAY (Transition Age Youth) ages birth through 25 years identified with complex mental health conditions who meet criteria to access Specialty Mental Health Services. The services are tailored to address severe behavioral health disorders, improve functional impairment, and increase developmentally appropriate coping skills. Services are delivered by multidisciplinary staff in clinic and field-based settings utilizing evidence-based and community defined practices. Outpatient specialty mental health services aim to decrease symptoms, prevent the necessity for higher level of care, and promote wellbeing, all while supporting children, youth, and TAY, to remain integrated within their families and communities.

CYWS represents a critical component of the behavioral health continuum of care, bridging the gap between community-based support, and more intensive treatment options. CYWS Program's partnerships with entities whose focus is children, youth, and TAY ensures a comprehensive holistic treatment approach. The goal of the program is for youth and families to be provided with the most appropriate level of care and services for their needs.

Also included are the following Mental Health Services Act-encumbered Innovation Projects:

- Outpatient services at Kedren Community Health Center to help bring holistic, cohesive care that addresses the whole child and family's needs to ensure a full continuum of care.
- Providing Access to Treatment, Health, Wellness and Youth Support (P.A.T.H.W.A.Y.S.) This project aims to enhance organizational capacity, achieve Medi-Cal certification, and ensure the long-term sustainability of programs by claiming Medi-Cal. This project will create a pathway ending in new CBOs contracting with the LACDMH to deliver claimable services, through a contract that is not the traditional SD M/C contract.

The following EI components are included as part of the program or service:

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

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

Yes

a. The following is a list of EBPs that apply:

- Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)
- Brief Strategic Family Therapy (BFST)
- Child and TAY
- Child-Parent Psychotherapy (CPP)
- Cognitive Behavioral Intervention for Trauma in School
- Depression Treatment Quality Improvement (DTQI)
- Family Centered EBPs
- Family Connections (FC)
- Functional Family Therapy (FFT)
- Incredible Years (IY)
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)
- Nurturing Parenting (NP)
- Parent-Child Interaction Therapy (PCIT)
- Portland Identification and Early Referral (PIER)
- Reflective Parenting Program (RPP)
- Strengthening Families (SF)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Triple P Positive Parenting Program (Triple P)
- UCLA Ties Transition Model (UCLA TTM)

3. Please describe intended outcomes of the program or service

- Access to Care: Increase timely access to appropriate mental health services
- Institutionalization: Reduce time spent in institutional settings.
- Justice-Involvement: Decrease the number of youth with behavioral health needs who become or remain involved with the justice system.
- Removal of Children from Home: Prevent unnecessary removal of children from their
- Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
- School Engagement: Enhance students' school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

4. 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

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

Table 8. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	83,040

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	83,870
FY 2028 – 2029	84,708

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

Included individuals projected to be served in Early Intervention. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

6. Program or service name #2: Screening and Linkage

This distinct program ensures that care can be provided as early as practicable in the onset of a behavioral health condition, with referrals for medical and social services as needed. It encompasses activities that support screening, assessment, and referral to behavioral health services through accessible channels such as telephone help lines, and supportive services. In addition, programming such as Wolf Connection and Friends of the Family aligns with Screening and Linkage efforts by providing complementary prevention and family-support activities: Wolf Connection offers experiential education and empowerment for youth via wolf-assisted learning, including the Power of the Pack digital education program and on-site visits; Friends of the Children delivers early family-centered mental health support, utilizing EBPs like PCIT and other family-focused interventions to reduce crises and strengthen family resilience. The integrated approach aims to improve early identification, facilitate timely access to care, and leverage community partnerships to support individuals and families across the care continuum.

7. The following EI components are included as part of the program or service:

- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals

8. 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

9. Please describe intended outcomes of the program or service

- Access to Care: Increase timely access to appropriate mental health services
- Justice-Involvement: Decrease the number of youth with behavioral health needs who become or remain involved with the justice system.
- Removal of Children from Home: Prevent unnecessary removal of children from their homes.
- Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
- School Engagement: Enhance students' school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

10. 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

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

Table 9. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	9,053
FY 2027 – 2028	9,143
FY 2028 – 2029	9,234

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

Included individuals served in programs listed above. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

12. Program or service name #3: Outreach and Engagement

This distinct program activates a multi-faceted approach to outreach, engagement, and early intervention across age groups, with a focus on caregivers, older adults, and youth. It prioritizes connections to community-based mental health and substance use services, leverages evidence-based practices (EBPs) and Community-Defined Evidence Practices (CDEPs) and seeks to reduce disparities in access for underserved and diverse populations. The program includes targeted outreach to aging networks and organizations serving older adults, as well as integrated youth services and school-based initiatives to support early identification, intervention, and referral.

Programs such as the United Mental Health Promoters (UMHP), TAY Drop-In Centers, and Community Resource Center are access-and-linkage programs in Los Angeles County. The UMHP aims to reduce mental health stigma in underserved cultural and linguistic communities by training and deploying community members to engage residents, connect them with the Department of Mental Health and other resources through culturally sensitive outreach, and provide stigma-reduction workshops, referrals, and frontline mental health support and triage. This county-wide outreach and empowerment effort delivers prevention services, engagement activities, and training to strengthen communities while creating career pathways for participants. The program supports eight UMHP teams (one contractor agency per Supervisory District) with nine staff per team, ensuring broad coverage and local presence.

13. The following EI components are included as part of the program or service:

- Outreach
- Access and Linkage: Screenings
- Access and Linkage: Assessments
- Access and Linkage: Referrals

14. 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

15. Please describe intended outcomes of the program or service

- Access to Care: Increase timely access to appropriate mental health services
- Justice-Involvement: Decrease the number of youth with behavioral health needs

who become or remain involved with the justice system.

- Removal of Children from Home: Prevent unnecessary removal of children from their
- Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
- School Engagement: Enhance students’ school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

16. 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

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

Table 10. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	171,000
FY 2027 – 2028	172,710
FY 2028 – 2029	174,437

- a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs
- Grew projected number of individuals served by 1% over the course of the next 2 fiscal years, Promotores reported 150,967 and Community Family Resource Center, 19,877. Total is 170,844, rounded up to 171,000 to account for the missing TAY Drop in center numbers.

18. Program or service name #4: Mobile Response

These distinct services are delivered by LACDMH clinicians who evaluate individuals at risk of self-harm, harm to others, or inability to meet basic needs; triage and de-escalation in the community; and coordination and dispatch of response teams to avoid hospitalization, incarceration, or injury. The approach emphasizes caring, trauma-informed intervention and strives to reduce stigma while supporting clients and families.

19. The following 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

20. 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

21. Please describe intended outcomes of the program or service

- Access to Care: Increase timely access to appropriate mental health services
- Justice-Involvement: Decrease the number of those with behavioral health needs who become or remain involved with the justice system.
- Removal of Children from Home: Prevent unnecessary removal of children from their
- Untreated Behavioral Health Conditions: Increase identification and timely treatment of behavioral health conditions, reducing progression, and improving functioning.
- School Engagement: Enhance students’ school engagement by preventing and treating behavioral health conditions, promoting consistent attendance, participation, graduation rates, and overall well-being.

22. 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

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

Table 11. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5,693
FY 2027 – 2028	5,749
FY 2028 – 2029	5,806

- a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs
 Included individuals served by existing Mobile Response services.
 Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to [7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis](#).

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

- a. **CSC program name:** Coordinated Specialty Care for First Episode Psychosis (formerly known as PIER and EPI-LA)
- b. **CSC program description:** An evidence-based, team and community-based service for Specialty Mental Health Service clients who have exhibited the onset of psychotic symptoms within the past five years; or who exhibit attenuated psychosis symptoms that meet criteria for clinical high-risk syndrome. Service age range:12-40 years of

age. DMH has 8 current provider sites. 5 of the 8 have gone through fidelity reviews as part of our involvement in the EPICAL project. Our services were initially focused on clients ages 12-26, however, due to DHCS guidance we are expanding the age group to age 40.

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

Table 12. Estimated Number of Individuals Eligible for CSC and Estimated Number of Teams Needed to Serve Total Eligible Population

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	1,604
Number of Uninsured Individuals	218
CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	196
Number of Teams Needed to Serve Total Eligible Population	46

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

Table 13. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	50	60	75
Total Number of Teams	8	10	13

4. Will the county’s CSC program be supplemented with other (non-BHSA) funding source(s)? Yes
 - a. Please list the other funding source(s): Medi-cal and EPSDT

Outreach and Engagement (O&E) Program

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

1. **Program or activity name #1:** Navigation
2. **Please describe the program or activity:** Activities include the following:
Engagement with community referral sources to assist individuals in accessing outpatient care, including linkage to the Full Service Partnership program.

Care Coordination/ Hospital Liaison: Care Coordination provides higher-touch support for individuals who are at risk of falling through the cracks in the system. This service involves more intensive engagement and follow-up to ensure clients successfully connect with and remain engaged in needed services. Hospital Liaison will go further that referral and linkage to include some service delivery. Assessment and testing when needed. This program priority population is the unhoused unlinked high utilizers that present with MH,

SUD or co-occurring disorders across our system in the emergency departments and locked LPS units. The goal is to ensure clients are not only referred to services, but that the connection is successful and sustained.

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

Table 14. Estimated Number of Individuals Served in O&E Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2,874
FY 2027 – 2028	2,902
FY 2028 – 2029	2,931

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

Included individuals receiving outreach from Service Area Navigation teams and Veterans' program. Grew projected number of individuals served by 1% over the course of the next 2 fiscal years.

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.

1. **Program or activity name #1:** Training and Technical Assistance
2. **The activity falls under the following category:** Workforce Recruitment, Development, Training and Retention
3. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in [Policy Manual Chapter 7, Section A.4.9](#)** Trainings focus on increasing clinical competencies across our diverse workforce. While training and technical assistance does not address the diversity of the workforce itself, which is more related to recruitment, DMH delivers comprehensive training that ensures that practitioners have the clinical competencies to deliver culturally relevant and competent services that are clinically effective and informed by the Department's cultural competence plan and array of cultural competence training. DMH also funds an annual Multi-Cultural Conference.
4. **Program or activity name #2:** Residency and Internship
5. **The activity falls under the following category:** Internship and Apprenticeship Program

6. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in Policy Manual Chapter 7, Section A.4.9** Charles Drew University is located in South LA and serves a large African American and Latino client base. The Pathways to Health program specifically serves to expose African American and Latino high school students to career opportunities in public mental health. The majority of student trainees in the Student Professional Development Program identify as Latino or African American. DMH has utilized recruitment campaigns, including social media postings that feature mental health staff of various ethnicities to demonstrate DMH's focus on inclusiveness. In addition, DMH has been working with 2 Historically Black Colleges and Universities to establish academic affiliation agreements to serve as training sites for their graduate students.
7. **Program or activity name #3:** Financial Incentives
8. **The activity falls under the following category:** Retention Incentives and Stipends
9. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in [Policy Manual Chapter 7, Section A.4.9](#)** These programs assist individuals from diverse backgrounds to consider public Specialty Mental Health employment. DMH has utilized recruitment campaigns, including social media postings that feature mental health staff of various ethnicities to demonstrate DMH's focus on inclusiveness. In addition, DMH has been working with 2 Historically Black Colleges and Universities to establish academic affiliation agreements to serve as training sites for their graduate students.
10. **Program or activity name #4:** Mental Health Career Pathways
11. **The activity falls under the following category:** Workforce Recruitment, Development, Training and Retention
12. **Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can be found in [Policy Manual Chapter 7, Section A.4.9](#)**
 This program prepares and enhances the skills for peer and parent providers who serve to enhance Specialty Mental Health Service delivery and provide meaningful roles for peers and parent partners. Recruitment efforts prioritize individuals with lived experience and individuals from historically underserved communities to support culturally responsive service delivery. Peer and Parent Partner Training provided through the programs include culturally responsive engagement, trauma-informed approaches, and strategies for working effectively with diverse populations. In addition, the programs encourage recruitment of bilingual Peer and Parent Partners to enhance language access and improve engagement with linguistically diverse communities.

Capital Facilities and Technological Needs (CFTN)

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

Capital Facilities Projects:

1. **Project name (#1):** High Desert CRTP
2. **The capital facilities project falls into the following category:** Meeting match

- requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
3. **Project Description:** The Crisis Residential Treatment Program will be the first adult CRTP in the Antelope Valley and will house 16 beds and provide a short-term alternative to hospitalization, serving 275 to 400 adults annually.
 4. **Project name (#2):** Jacqueline Avant Children and Family Center
 5. **The capital facilities project falls into the following category:** 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.
 6. **Does the project involve leasing or renting to own a building:** N
 7. **Project Description:** The project was an expansion of the current outpatient service capacity located at Martin Luther King (MLK). The Children's Outpatient Program, a children and youth crisis stabilization unit (CSU) will also be housed on the third (3rd) floor of the MLK Jacqueline Avant Children and Family Center Pediatric Outpatient Center and CSU.
 8. **Project name (#3):** LA General Urgent Care Center (UCC)
 9. **The capital facilities project falls into the following category:** 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.
 10. **Does the project involve leasing or renting to own a building:** N
 11. **Project Description:** The UCC provides immediate, walk-in access to behavioral health services for people in crisis, acting as an alternative to hospital ERs for psychiatric needs, offering assessments, counseling, medication help, and stabilization to connect patients with ongoing care without requiring overnight stays, The UCC facility would operate on a 24/7 basis, and its clients can remain in the facility for a duration not to exceed 24-hours. If a client is not able to safely return to their previous environment, they may be transferred to one of the LA General CRTPs across the shared driveway for short-term residential care. Likewise, its proximity to Los Angeles General Medical Center is of importance. Clients at the proposed MHUCC in need of further medical care or inpatient mental health care may be transferred to the Medical Center.
 12. **Project name (#4):** East San Gabriel Valley Clubhouse
 13. **The capital facilities project falls into the following category:** 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.
 14. **Does the project involve leasing or renting to own a building:** N
 15. **Project Description:** A Club House provides a non-clinical therapeutic community for people living with serious mental illness who work in partnership with our members to ensure they are at the center of their own recovery.
 16. **Project name (#5):** Urgent Care Center (UCC)
 17. **The capital facilities project falls into the following category:** Renovating or constructing buildings that are privately owned.
 18. **Project Description:** Psychiatric UCCs are Medi-Cal certified and Lanterman Petris Short (LPS) designated free-standing crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support 24-hours per day, 7 days per week. UCCs also provide case management for individuals experiencing

psychological distress and/or psychiatric crisis. UCC services, including integrated services for co-occurring disorders, are focused on stabilization and linkage to recovery-oriented community-based resources. Clients are permitted to stay in the UCC chair 23 hours and 59 minutes that are licensed by the California Department of Health Care Services.

19. **Project name (#6):** Tenant Improvement
20. **The capital facilities project falls into the following category:** Establishing a capitalized repair or replacement reserve.
21. **Project Description:** Funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded BHSAs programs which includes the purchasing of equipment and furniture.

Technological Needs Projects:

1. **Project name (#1):** System Maintenance and Upgrades
2. **The following are the focus area(s) of the project:**
 - Data exchange and interoperability
 - Data security and privacy
 - Data warehouse
 - Electronic health record system
 - Imaging/paper conversion
 - Monitoring
 - Online information resources for individuals/families
 - Personal health record system
 - Resources to support web content and mobile app accessibility
 - System maintenance costs
 - Telemedicine
3. **Please describe the project:** Reserve of funds needed to maintain and upgrade system State requirements and local County needs. This investment will enable seamless data exchange and interoperability, strong data security and privacy, and robust data analytics. Funding supports a centralized data warehouse for reporting and decision support, a core Electronic Health Record (EHR) system for patient encounters and care plans. It also covers continuous monitoring for system and security oversight, and user-friendly online information resources for individuals and families.

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](#)

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

Table 15. Estimated Number of Individuals Eligible for Full Service Partnership Services

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	29,452
Number of Uninsured Individuals	5,027
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	9,615

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

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

Table 16. Estimated Number of Individuals Eligible for ACT and FACT and Estimated Number of Teams Needed to Serve Total Eligible Population

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3,817
Number of Uninsured Individuals	652
FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	1,909
Number of Uninsured Individuals	2,235
ACT and FACT Practitioners and Teams Needed	Estimates

Number of Practitioners Needed to Serve Total Eligible Population	680
Number of Teams Needed to Serve Total Eligible Population	68

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

Table 17. Total Number of ACT and FACT Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	160	472	785
Total Number of Teams	16	47	78

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

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

Table 18. Estimated Number of Individuals Eligible for FSP ICM and Estimated Number of Teams Needed to Serve Total Eligible Population

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	23,726
Number of Uninsured Individuals	4,049
FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	1,115
Number of Teams Needed to Serve Total Eligible Population	223

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-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 19. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	475	682	893
Total Number of Teams	73	105	137

High Fidelity Wraparound (HFW) Eligible Population

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

Table 20. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population		Estimates
Number of Medi-Cal Enrolled Individuals		14,166
Number of Uninsured Individuals		989
HFW Practitioners and Teams Needed		Estimates
Number of Practitioners Needed to Serve Total Eligible Population		5,312
Number of Teams Needed to Serve Total Eligible Population		106

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-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 21. Total Number of HFW Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5,312	5,312	5,312
Total Number of Teams	106	106	106

Individual Placement and Support (IPS) Eligible Population

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

Table 22. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population

IPS Eligible Population		Estimates
Number of Medi-Cal Enrolled Individuals		3,172
Number of Uninsured Individuals		1,269
IPS Practitioners and Teams Needed		Estimates
Number of Practitioners Needed to Serve Total Eligible Population		222
Number of Teams Needed to Serve Total Eligible Population		111

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-operated and county-contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

Table 23. Total Number of IPS Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	30	60	100
Total Number of Teams	15	30	50

Full Service Partnership (FSP) Program Overview

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

1. **Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP? Yes**
 - a. **Please describe how the estimated practitioners will provide more than one EBP:** Some FSP, ACT and FACT practitioners may also be trained in IPS or any other EBP determined to be appropriate to serve the population. Within ACT and FACT, the expectation is that practitioners are fully dedicated to ACT and FACT, so EBPs would be provided to the ACT/FACT population.
2. **Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual’s natural supports:**

Los Angeles County Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement and repeat hospitalizations.

FSP programs were designed to serve people in the community rather than in locked state hospitals. By engaging mental health consumers in their own care and providing services tailored to their stated individual needs, FSPs can incorporate family and supports as identified by individual clients during the treatment planning. FSP Adult delivers multidisciplinary, team-based care designed to address the whole person. Teams may include licensed clinicians, psychiatrists, case managers, nurses, substance use specialists, and peer staff. Decisions are collaborative, with ongoing risk assessment and individualized treatment planning that prioritizes safety. The integrated model targets psychiatric symptoms, substance use, medical issues, housing instability, legal involvement, and psychosocial stressors through multiple modalities such as individual therapy, crisis intervention, medication management, harm reduction, case management, and field outreach.

The program emphasizes flexible funding to meet urgent needs that affect mental health stability. Examples include assisting with benefits applications, covering essential needs like groceries and clothing, and supporting sober living placements. This approach aims to prevent rapid decompensation, re-incarceration, and hospitalization by addressing basic needs alongside clinical care.

Persistent outreach and family collaboration are core components. The FSP Adult model prioritizes ongoing engagement, including locating missing clients, re-engaging those who disengage, and maintaining contact with hospitals, jails, shelters, and encampments. When appropriate, the team involves families and natural supports in treatment planning, crisis prevention, and safety planning, while respecting client autonomy and consent. The overarching goal is a trauma-informed, whole-person approach that integrates clinical care with social supports to promote recovery and stability.

DMH can also ensure providers are employing a whole-person, trauma informed approach by ensuring training, and ensuring whole person approaches are reflected in policy.

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

The Los Angeles County Department of Mental Health (LACDMH) is engaged in various efforts to address and reduce disparities in mental healthcare access and outcomes for underserved populations. Key strategies and initiatives include but are not limited to prioritizing hiring of individuals with language capabilities reflective of client needs, partnering with mission driven providers who provide culturally competent care, and dialoging and training on cultural competency. Countywide strategies include Cultural Competency and Responsiveness; Mental Health promoters to reduce stigma in underserved communities by raising awareness and resources; Community Engagement and Outreach; Efforts are made to integrate physical health, mental health, and substance abuse services; LACDMH utilizes evidence-based practices and community defined evidence based practices to improve service delivery for ethnic populations.

Each Fiscal Year (FY), several activities are implemented and tracked to determine disparities in access to mental health services across three MHSAs including Community Services and Support (CSS), Workforce, Education, and Training (WET), and Prevention Early Intervention (PEI). FSP disparities are represented in the CSS component of our MHSAs. With that said, we've identified disparities in our African American (AA), Asian Pacific Islander (API), Latino, and American Indian/Alaska Native (AI/AN) populations. We've used several data sources that are delineated in our 2025 Cultural Competency Plan including but not limited to Medi-Cal enrolled population. Additional data sources specific to FSP have included the following:

- Integrated Behavioral Health Information System (IBHIS) is equipped to provide reports on "Active" clients through various COGNOS reports which reflect basic demographic information to assist, support or enhance other data sets and sources with ability to analyze disparity populations served.
- Outcomes Division provides data on comprehensive demographics for disparity analysis and comparison across populations. Through this reporting system we can evaluate what disparities exist and how they are being served.
- Our DMH NAPA system provides data on provider programs and specialty mental health services available to ensure FSP cases are assigned to providers that have the capacity and staff to deliver linguistic, age and culturally sensitive services.
- Referral Tracking System (RTS) provides FSP specific data in which demographics are reflected in our semi-monthly reports and denotes client demographics related to ethnicity, legal and housing. In addition, RTS also provides data on language, gender and gender identity.
- Through our coordination with UCLA Center of Excellence, Public Mental Health Partnership we are able to provide resources and recommend trainings for providers to ensure they have the access to the most current and updated trainings for outreaching, engaging, delivering culturally sensitive services across various populations including Latinx, African American, LGBTQ+, Older Adults.
- Systemwide strategies to reduce disparities have also assisted in reducing those same disparities in FSP. Those include but are not limited to the following:
 - Community Education Multi-media campaigns FSP-Countywide Networks
 - FSP-Ethnic Targets
 - EBPs/CDEs for Ethnic Populations
 - Field-Based Services
 - FSP-Enrollment Flexibility
 - Language Assistance Services

- Multi-cultural Staff Development
- Outreach and Engagement Activities
- Integrated Services (Physical, Mental Health and Substance Use)
- Specific Ethnic/Language Groups
- Provider Communication/Support
- Training/Case Consultation

Specific examples of how we are addressing disparities in FSP have included the following: We collaborate with AAPI Equity Alliance to ensure API community mental health needs are being met by having several therapists with a variety of API language capabilities such as Mandarin, Cantonese, Japanese, Filipino, Vietnamese, Cambodian, and Korean to reflect most common spoken languages in the Los Angeles County as well as other API languages.

Our Service Area (SA) Navigators are subject matter experts when determining programs, linkage needs, and providers equipped to deliver services for clients with one or more qualities related to disparities. For example: we have specialty FSP providers that have expertise in working with a particular age group or populations including but not limited to Social Model Recovery and Tarzana Treatment Center to serve COD/SUD clients; Starview that serves LGBTQ+ and TAY clients; American Indian Counseling Center; Long Beach API Family Mental Health Center, Coastal API Family Mental Health Center, Asian Pacific Counseling and Treatment Center, and Heritage who serve older adult clients. When a referral comes in with a particular need we are able to route them accordingly, if available in that service area.

4. The following are goals the County is hoping to support based on the county's allocation of FSP funding :

Access to care, Homelessness, minimize time in institutional settings, reducing justice involvement, reducing removal of children from the home, reducing untreated behavioral health conditions, and increase engagement in schools

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

LACDMH FSP programs employ "relentless engagement" efforts whenever possible to ensure those vulnerable populations are engaged and enrolled in treatment. Once enrolled, the service model requires regular case review by the team, as well as a minimum of 4 services per month, ensuring regular engagement. In addition, motivational interviewing and other practices are used to support individuals on their road to recovery.

a. (Optional) Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

In addition to the strategies outlined above for FSP ICM, DMH has some programs that engage in proactive outreach to engage or re-engage individuals in care including the Homeless Outreach Mobile Engagement (HOME) team as well as the Interim Housing Outreach Program (IHOP) which proactively engages individuals residing in transitional housing settings to engage or re-engage them in services.

6. Please describe how the county will comply with the required FSP levels of care

(e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

LACDMH has implemented the use of the Levels of Care Utilization System (LOCUS), which is a standardized assessment tool used to determine the appropriate level of care for individuals with mental health or substance use disorders. The LOCUS will be used throughout all LACDMH programming/services including FSP levels of care. LACDMH has also completed a needs assessment for ACT/FACT, FSP-ICM, and HFW, and plan to transition existing FSP providers into doing FSP-ICM and ACT. We plan on phasing in our providers and assessing additional need for FSP levels of care as we go. We may release a solicitation process for both programs should the need arise.

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

a. **Primary substance use disorder (SUD) FSPs:** No

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

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

Los Angeles County has multiple outreach teams some of which are DMH funded and some of which are not, but coordinate with DMH to refer to care. DMH has developed a universal referral form these community and homeless outreach teams, use to refer for DMH services. DMH also uses screening tools with Managed care to ensure the correct level of care for referrals to specialty mental health. DMH partners with entities in justice involvement settings who refer to FSP care, and finally, DMH employs hospital liaisons that assist in referring individuals to the right level of care within the DMH system of care. LACDMH has regional navigation teams who are responsible for connecting these referrals with the most appropriate FSP provider.

In addition, DMH has some programs that do proactive outreach to engage or re-engage individuals in care including the Homeless Outreach Mobile Engagement (HOME) team as well as the Interim Housing Outreach Program which proactively engages individuals residing in transitional housing settings to engage or re-engage them in services.

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

i. **Please describe the other recovery-oriented services the county's FSP program will include:** LACDMH will be expanding the Individual Placement and Support (IPS) as part of FSP programming to assist individuals with Severe Mental Illness (SMI) with finding and maintaining competitive employment.

8. If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams.

Other FSP services include:

Clubhouse Model

DMH is building Clubhouse model programs across LA County which can complement care.

Hollywood 2.0

Hollywood 2.0 is a continuing MHSA-encumbered Innovation project that will help build the evidence base for new statewide behavioral health strategies by testing a holistic, community-based continuum of care model that integrates psychosocial rehabilitation with flexible, person-centered service delivery. The pilot is designed to assess whether an integrated “clinic without walls” model can improve outcomes for individuals with severe mental illness compared to more traditional, siloed systems of care.

H20 is inspired by the public mental health system in Trieste, Italy which incorporates a community-based approach to support individuals living with severe mental illness. This method is fundamentally different from existing services in the Department of Mental Health (DMH) in two key ways:

1. Care is organized as a continuous, integrated system rather than as separate programs with rigid eligibility and referral criteria; and
2. Services prioritize functional recovery, autonomy, and community participation alongside clinical treatment.

Through the Hollywood Mental Health Cooperative, the H20 pilot integrates a full array of services, including outpatient care, intensive field services, urgent care, housing navigation, employment support, and other social services, within a single multidisciplinary team structure. This model increases flexibility to match individuals to the appropriate level and type of care as needs change, reducing service fragmentation and barriers to engagement.

By tracking outcomes related to service engagement, housing stability, crisis and emergency service utilization, and functional recovery, the H20 pilot will generate actionable data and implementation lessons that can inform effectiveness, scalability, and replication of similar community-based mental health strategies.

Interim Housing Outreach Program (IHOP)

IHOP is a continuing MHSA-encumbered Innovation project. The program is a collaborative project between LA County Departments of Mental Health (DMH), Public Health-Substance Abuse Prevention and Control (DPH-SAPC), and Health Services-Housing for Health (DHS-HFH). This Innovative Project will help build the evidence base for the effectiveness of new statewide strategies by testing a coordinated, cross-department service delivery model embedded within interim housing settings.

By integrating specialty mental health, substance use disorder, and physical health services within interim housing, the program will generate evidence on whether multi-disciplinary, field-based teams can improve access to care, address functional impairments, support transitions to permanent housing, improve health outcomes, and reduce returns to homelessness.

Specialty mental health services provided through the IHOP include outreach & engagement, triage, peer support, screening/assessment, individual and group rehabilitation and therapy, medication evaluation/administration, intensive case management, and crisis intervention. Substance use disorder (SUD) treatment delivered by DPH-SAPC includes individual and group support sessions, psychoeducation on substance use, linkage to medication for addiction treatment (MAT), and harm reduction services, (e.g. fentanyl test strips, naloxone, syringe services etc.). For residents in need of more intensive SUD services, the IHOP teams can facilitate admission to detox and residential treatment

programs.

Data collected on service utilization, housing outcomes, health and behavioral health indicators, and participant engagement will inform the effectiveness, feasibility, and scalability of this model. Findings from the pilot will support decision-making around replication of integrated, housing-based service models and the development of future statewide approaches to addressing homelessness, behavioral health, and health equity.

Transformation from Peer Resource Centers to Clubhouses

LACDMH will continue to transform the existing Peer Resource Centers into the Clubhouse model, assuring alignment with BHSA and BH Connect. To support and facilitate this system-wide transformation, LACDMH will contract with a consultant to assess the system's readiness for these changes, evaluate and identify effective strategies, and successfully redesign and implement the Clubhouse model.

This project will establish clubhouses by supporting, educating, and providing centralized technical assistance to providers. The goal is to phase in an expansion of billable revenue streams. This project is a continuing MHSAs-encumbered Innovation project.

Consultation Services for FSP

The FSP program provides a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness. This is a continuing MHSAs-encumbered Innovation project that will allow for technical assistance and support for outpatient providers transitioning to become Full Service Partnership providers and will support any newly contracted Full Service Partnership providers.

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

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

DMH has reviewed data related to TAY in need of services under FSP.

DMH has developed an "Office of TAY" and has developed a TAY field based FSP program which serves TAY and their unique needs. DMH has an existing TAY drop in center allowing for ongoing engagement of at risk youth. In addition, DMH has robust non-MHSA/BHSA funded programming within the Juvenile Justice settings, and discharged youth in need are referred to FSP upon release.

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

Representatives from the LGBTQ+ community and advocacy groups participated in the Community Planning process when the FSP, ACT, and FACT programs were presented. DMH is committed to ensuring that FSP-HFW programming is inclusive and responsive to the needs of all youth populations, including LGBTQ+ youth. LGBTQ+ youth who experience disproportionate behavioral health and housing instability risks. DMH is working with their BHSA administration to engage LGBTQ+ youth in the community planning processes and is collaborating with the Youth Commission and the Commission of Children and Families to incorporate youth voice into program development. These efforts will strengthen culturally responsive and

affirming services within HFW-FSP programs.

c. **In the child welfare system**

DMH reviewed data related to children and youth in the child welfare system with stakeholders, identifying regional concentrations where services are most needed. DMH partners closely with the Child Welfare System to triage care and provide care attuned to the unique needs of children and youth in or at risk of being in the child welfare system. DMH has a non MHSA/BHSA funded program titled Specialized Foster Care which partners directly with DCFS offices regionally, provides screening and linkage. All FSP providers deliver ICC and IHBS services and will be trained to deliver HFW under BHSA.

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

a. Older adults: DMH has established FSP contracts with mission driven providers who specialize in services to the older adult population. DMH will also be transforming our Genesis program to FSP ICM, this program specifically provides outreach and focused on older adults who are home bound.

b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+): DMH has established FSP contracts with mission driven providers who specialize in services to the LGBTQ+ population. DMH will continue to expand service delivery to this population in the coming years.

c. In, or are at risk of being in, the justice system: DMH has established FSP contracts with mission driven providers who specialize in services to the justice involved population. In addition, we have partnerships with the Office of Diversion and Re-entry to facilitate individuals leaving the justice system and support their transition to housing and enrollment in the FSP program. Finally, DMH has the Men's and Women's wellbeing program which will transform to FSP ICM in FY 26/27. This program is dedicated to serving individuals coming out of the justice system with the goal of promoting recovery and preventing recidivism.

In addition, one of the cornerstones of the Mental Health Services Act (MHSA) is to empower underrepresented ethnic/cultural groups and to give them a voice in the stakeholder process. The term **Underserved Cultural Communities (UsCC)** refers to communities historically unserved, underserved and inappropriately served, in terms of mental health services. As a result of MHSA, UsCC subcommittees have been developed by LACDMH to address the needs of targeted ethnic/cultural communities.

The UsCC subcommittees are an important part of the community stakeholder engagement process. The UsCC subcommittees work closely with community partners and consumers to increase the capacity of the public mental health system and to develop culturally competent recovery-oriented policies and services specific to the UsCC communities. Through our regular monthly meetings with stakeholders, we've shared data and presented how BHSA will change FSP landscape. Through this process, we've looked at the unique needs of Children, Adults, Older Adults, LGBTQ+, and those that are criminal justice involved. Robust discussions and analysis of existing data have led to developing the county's FSP program.

Assertive Field-Based Substance Use Disorder (SUD) Questions

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

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

LACDMH will leverage existing SUD treatment services for all field-based programs including FSP to ensure clients have rapid access to Medication Assisted Treatment (MAT) and promote a person-centered approach to provide access to lifesaving care, prevent overdose and improve the quality of life for individuals living with SUDs. LACDMH has already trained directly operated Psychiatry providers in MAT and intend to expand this training to increase MAT access within FSP under FSP ICM, ACT, and FACT. In addition, LA has a robust availability of MAT services, including a hotline that can assess and prescribe MAT immediately and offer linkage to ongoing MAT services. LACDMH will prioritize expanding MAT capabilities within teams, while also helping providers access community based services. LACDMH will expand MAT capacity and training starting July 1, 2026, in order to meet the assertive field-based SUD program requirements.

Table 24. Existing Programs for Assertive Field-Based SUD Treatment Services: Targeted Outreach

Existing Program
CA Bridge Hospitals; Syringe exchange programs; Harm Reduction Vending Machines
Program Description
<ul style="list-style-type: none"> • CA Bridge Hospitals: Ensures that every hospital in California provides 24/7 access to evidence-based care, treating substance use disorder (SUD) like any other life-threatening condition. CA Bridge is working with hospital emergency departments (EDs) to provide immediate access to medications for addiction treatment (MAT) to anyone seeking help. • Syringe Exchange Programs: Syringe services programs have been operating in California, providing sterile syringes, collecting used ones, and acting as points of access to health education and care for people who inject drugs Harm Reduction Vending Machines: are an evidence-based strategy to provide essential harm reduction supplies to people who use drugs. Harm reduction vending machines are similar to drink or snack vending machines, but may be stocked with supplies such as naloxone, sterile injection equipment, condoms, sharps containers, first aid kits, and pregnancy tests.
Current Funding Source
Los Angeles County Department of Public Health and other Non BHSA funding
BHSA Changes to Existing Program(s) to Meet BHSA Requirements

N/A
Expected Timeline of Operation
Currently Active

Table 25. Existing Programs for Assertive Field-Based SUD Treatment Services: Mobile-Field Based Programs

Existing Program
Homeless Outreach & Mobile Engagement (HOME), Full Service Partnership
Program Description
<ul style="list-style-type: none"> • HOME: The Homeless Outreach & Mobile Engagement (HOME) Program serves unhoused adults with severe mental illness who decline other services. The program aims to meet the most vulnerable and disengaged in the community where they are at and do whatever it takes to help them move towards housing and recovery. • FSP: Adult FSP programs assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have co-occurring mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community and other locations. Embedded in Full Service Partnerships is a commitment to deliver services in ways that are culturally and linguistically competent and appropriate. <p>HOME team has developed several innovations in field-based space. HOME Team staff psychiatrists are expertly trained street psychiatrists who are extensively trained in working with unhoused individual with SMI and cooccurring SUD. All street psychiatry evaluations are completed in-person, which allows for culturally and structurally informed treatment planning that is completed within the realities of each individual's living conditions. Medication regimens are designed to be practical and sustainable in the street. Prescriptions are sent to pharmacies that can pre-package oral medications (including oral MAT) in individual bubble packs. This allows HOME staff to deliver daily medication doses to clients in the field and directly observe compliance with all medications including MAT. Protocols to complete phlebotomy in the field have also been developed. Mobile labs can thus be completed by HOME street psychiatrists to screen for health conditions and monitor psychiatric/MAT treatment appropriately. HOME team has nursing support within their multidisciplinary teams with training and experience to complete vital signs and administer long-acting injections (including injectable MAT) in the field. Licensed medication rooms for each HOME team have been created where psychiatric medications including MAT can be stored and rapidly delivered/administered to clients who accept treatment. HOME also provides linkage to housing and residential services to address homelessness and support recovery beyond the streets. For clients who are too impaired to be treated on the street or outpatient settings, HOME has developed partnerships with hospitals and admit clients who meet criteria for acute stabilization and inpatient initiation of MAT. HOME team has created avenues of collaboration between street medicine, primary care, specialty medical providers, and drop-in centers in the community to link clients for additional SUD services (including MAT) whenever needed.</p> <p>All field-based teams within our system will be trained on the HOME Team model and incorporate their innovations when appropriate. They will also be trained in delivering AFBSS, COD/SUD treatment, and deliver MAT services via staff psychiatrist or link to MAT via DHS MAT hotline or connect individuals to street medicine providers and open access clinics that are available in the community. All members of the field-based team will be trained in COD/SUD services in addition to having SUD counselor as part of the team.</p>
Current Funding Source
<ul style="list-style-type: none"> • HOME: MHSA Linkage Services • FSP: MHSA FSP
BHSA Changes to Existing Program(s) to Meet BHSA Requirements

<p>Both of these programs will be aligned with BHSA FSP requirements to ensure IPS, AFBSS/MAT, and COD/SUD service delivery. Both of these programs will be aligned with BHSA FSP requirements to ensure IPS, AFBSS/MAT, and COD/SUD service delivery.</p> <p>LACDMH will implement intensive training with existing Full Service Partnership providers to enhance Co-occurring disorder services and outreach skills. Training will include conducting an ASAM screening, psychiatry training to deliver MAT, understanding the network of available MAT services in LA County, and team based care and documentation for individuals with co-occurring disorders.</p> <p>LACDMH will train psychiatrists and expand its capacity to deliver MAT across both directly operated and contracted services, while mapping resources to ensure rapid access to partner services, including FQHCs and non-DMH entities.</p>
<p>Expected Timeline of Operation</p>
<p>Currently Active</p>

Table 26. Existing Programs for Assertive Field-Based SUD Treatment Services: Mobile-Open-access clinics

<p>Existing Program</p>
<p>Homeless Outreach & Mobile Engagement (HOME), Full Service Partnership</p>
<p>Program Description</p>
<p>DMH offers open access field based MAT through its HOME team street psychiatrists. DMH FSP also refers to open access clinics present in Los Angeles County, examples include FQHCs and partnership with health street teams.</p> <p>HOME team has developed several innovations in field-based space. HOME Team staff psychiatrists are expertly trained street psychiatrists who are extensively trained in working with unhoused individual with SMI and cooccurring SUD. All street psychiatry evaluations are completed in-person, which allows culturally and structurally informed treatment planning that is completed within the realities of each individual's living conditions. Medication regimens are designed to be practical and sustainable in the street. Prescriptions are sent to pharmacies that can pre-package oral medications (including oral MAT) in individual bubble packs. This allows HOME staff to deliver daily medication doses to clients in the field and directly observe compliance with all medications including MAT. Protocols to complete phlebotomy in the field have also been developed. Mobile labs can thus be completed by HOME street psychiatrists to screen for health conditions and monitor psychiatric/MAT treatment appropriately. HOME team has nursing support within their multidisciplinary teams with training and experience to complete vital signs and administer long-acting injections (including injectable MAT) in the field. Licensed medication rooms for each HOME team have created where psychiatric medications including MAT can be stored and rapidly delivered/administered to clients who accept treatment. HOME also provides linkage to housing and residential services to address homelessness and support recovery beyond the streets. For clients who are too impaired to be treated on the street or outpatient settings, HOME has developed partnerships with hospitals and admit clients who meet criteria for acute stabilization and inpatient initiation of MAT. HOME team has created avenues of collaboration between street medicine, primary care, specialty medical providers, and drop-in centers in the community to link clients for additional SUD services (including MAT) whenever needed.</p> <p>All field-based teams within our system will be trained on the HOME Team model and incorporate their innovations when appropriate. They will also be trained in delivering AFBSS, COD/SUD treatment, and deliver MAT services via staff psychiatrist or link to MAT via DHS MAT hotline or connect individuals to street medicine providers and open access clinics that are available in the community. All members of the field-based team will be trained in COD/SUD services in addition to having SUD counselor as part of the team.</p>
<p>Current Funding Source</p>
<ul style="list-style-type: none"> HOME: MHSA Linkage Services

<ul style="list-style-type: none"> • FSP: MHSA FSP • Non-behavioral health services funding
BHSA Changes to Existing Program(s) to Meet BHSA Requirements
N/A
Expected Timeline of Operation
Currently Active

Table 27. New Programs for Assertive Field-Based SUD Treatment Services:

Targeted Outreach

New Program(s)
ACT/FACT, FSP-ICM
Program Description
DMH will identify the highest-need outreach locations by collaborating with Emergency Medical Services (EMS), law enforcement, managed care plans (MCPs), health systems and hospitals, FQHC/RHS', individuals with living or lived experience, and other partners to obtain data on regions and populations with high rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics on a regular basis.
Planned Funding
BHSA FSP
Planned Operations
Both of these programs will be aligned with BHSA FSP requirements to ensure IPS, AFBSS/MAT, and COD/SUD service delivery.
LACDMH plans to train Full Service Partnership providers to enhance Co-occurring disorder services and outreach skills. Training will include conducting an ASAM screening, psychiatry training to deliver MAT, understanding the network of available MAT services in LA County, and team based care and documentation for individuals with co-occurring disorders.
Expected Timeline of Operation
July 1, 2027

Table 28. New Programs for Assertive Field-Based SUD Treatment Services:

Mobile-Field Based Programs

New Program(s)
IHOP, VMFS, HSSP, GENESIS, TAY Field Based Teams
Program Description
<ul style="list-style-type: none"> • Interim Housing Outreach Program (IHOP): is a field-based, multidisciplinary teams that are specifically dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health, including substance use, and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness. • Veteran Military Family Services (VMFS): VMFS's are a peer-driven approach that fosters trust, encouraging veterans to seek support for housing, employment, education, and trauma-related needs. These services are delivered by field based multi-disciplinary teams • Housing and Supportive Services Program (HSSP): A program that provides comprehensive and intensive field-based specialty mental health services designed to meet the unique needs of formerly unhoused individuals living in tenant-based or project-based PSH that have a Serious Mental Illness (SMI) or Severe Emotional Disturbance (SED) • GENESIS: The GENESIS Older Adult Program offers field-based outpatient mental health services for older adults who are living with a severe mental illness and are unable to access services due to impaired mobility, frailty, or other limitations. GENESIS provides specialized services to meet the unique needs of people ages 60 years and above.

<ul style="list-style-type: none"> TAY Field Based Teams: These are multi-disciplinary teams that provide outreach and engagement to transitional age youth (ages 16-25) that have SMI/SED and need specialty mental health services and linkage to other services such as housing, employment, etc.
Planned Funding
BHSA FSP
Planned Operations
LACDMH will provide compressive training to providers to enhance Co-occurring disorder services and outreach skills. Training will include an conducting an ASAM screening, psychiatry training to deliver MAT, understanding the network of available MAT services in LA County, and team based care and documentation for individuals with co-occurring disorders.
Expected Timeline of Operation
July 1, 2026

Table 29. New Programs for Assertive Field-Based SUD Treatment Services:

Open-access clinics

New Program(s)
N/A
Program Description
N/A
Planned Funding
N/A
Planned Operations
N/A
Expected Timeline of Operation
N/A

Medications for Addiction Treatment (MAT) Details

- 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**

The gap will be assessed using the DHCS provided number for the calendar year of 2024, which is 54.11% (7,972 of 14,732 Medi-Cal members with (OUD) in LA County received MOUD). This number represents met and unmet need. We will also use Medi-Cal claims data (MCP, SMHS, DMC-ODS) where an OUD (F11.*) or AUD (F10.*) was documented and then compare this with Medi-Cal Rx and DMC-ODS data on MOUD and MAUD receipt. Currently, 2,904 (40%) of FSP clients have a occurring SUD, and are receiving co-occurring care. As we get closer to BHSA implementation, we will be providing training on Assertive Field Based Initiation of SUD services for all our field-based programs, specifically FSP. We hope that this will increase engagement and linkage to Medication for Addiction Treatment (MAT) for those in need. We will also avail ourselves, and leverage, when possible, other resources such as DHS Hotline for MAT services to ensure clients are linked as soon as possible. Expanding our open access clinics to ensure clients are connected to MAT countywide is also a goal. In addition, MAT training for psychiatrists who will be providing services as part of a field-based team will be essential; as well as training the entire team in treating co-occurring substance use clients. By using some of the above strategies we hope to address unmet needs of those individuals who are not yet in our system.

- The county will implement the following practices to ensure same day access to**

MAT:

- Contract directly with MAT providers in the county
- Operate MAT clinics directly
- Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
- Leverage telehealth model(s)
- Other strategy: The plan to meet this need includes: providing start-up funding to DMC-ODS certified clinics to hire medical clinicians so these settings have medical clinicians on staff can provide addiction medication services to clients. We plan to support agencies with medical clinicians working collaboratively with agencies who don't have this staffing to enable cross-coverage between treatment agencies. For settings where such access remains not immediately feasible, DPH-SAPC is supporting an open-access telephone line to which provides same-day access to addiction medication services.

3. Utilizing the strategies indicated above, the county will provide the following forms of MAT:

- Buprenorphine
- Methadone
- Naltrexone
- Other:

Acamprosate	Disulfiram	Topiramate	Gabapentin
Baclofen	Ondansetron	Varenicline	Bupropion
Benzodiazepines	Barbiturates	Anticonvulsants	Mirtazapine
Modafinil	Topiramate	Methylphenidate	Modafinil
N-acetyl cysteine	Nicotine Replacement	Dextroamphetamine/ Amphetamine	

Housing Interventions

Planning

For related policy information, refer to [7.C.3 Program priorities](#) and [7.C.4 Eligible and priority populations](#).

System Gaps

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

Table 30. System Gaps

No Gap	Small Gap	Medium Gap	Large Gap
Accessory dwelling units, including junior accessory dwelling units	Housing in mobile home communities	Apartments, including master-lease apartments	Supportive Housing
(Permanent) Tiny homes	(Permanent) Single room occupancy units	Single and multi-family homes	(Permanent) Recovery/sober living housing, including recovery-oriented housing
	(Interim) Single room occupancy units	Hotel and Motel stays	(Interim) Recovery/sober living housing, including recovery-oriented housing
	Shared housing	Peer Respite	Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
	License-exempt room and board	Recuperative Care	Permanent rental subsidies
	Short-Term Post-Hospitalization housing		Housing supportive services
	(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units		
	Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)		
Non-congregate interim housing models			

2. **What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system**

utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?

- a. DMH leverages a wide range of non-BHSA housing resources to assist clients in securing housing resources. These include the following:
 - Behavioral Health Bridge Housing (BHBH) for short to mid-term housing, including interim housing, rental assistance, and Enriched Residential Care (ERC) - Plus
 - Community Care Expansion Preservation Program - Operating Subsidy Payments for licensed residential care facilities through DMH's ERC program
 - Substance Abuse and Mental Health Services Administration for licensed residential care facilities through DMH's ERC program and PATH for Housing Assistance such as security deposits, furniture and utilities in permanent supportive housing.
 - Federal subsidies including Continuum of Care (CoC) and Housing Choice Vouchers through 11 active contracts with the Housing Authority of the City of Los Angeles (HACLA) and Los Angeles County Development Authority (LACDA). DMH also has agreements with HACLA for Homeless Section 8 and Tenant-Based Supportive Housing; however, they are currently in short-fall so these resources are not currently available. Also, the CoC program is in jeopardy because of Federal priority changes to the program.
 - Mental Health Services Act capital investments in PSH since 2008
 - Net County Cost for the DMH Interim Housing Program
 - 2011 State Realignment for the DMH Housing Assistance Program (HAP)
 - Homekey+ investments will also increase access to housing
 - CalAIM Community Supports resources including the Housing Trio and Transitional Rent (TR).
- b. Los Angeles County has the Measure A sales tax and State HHAP which funds a variety of housing resources that that DMH clients may be able to access, depending on eligibility criteria. Also, DMH clients can access other housing resources through a variety of investments by the 85 cities in Los Angeles (this excludes the three cities in the Tri-City area).
- c. DPH-SAPC leverages a range of non-BHSA resources and partnerships to expand access to housing for BHSA-eligible individuals:
 1. Local Resources:
 - Measure H/A: Funds interim housing, Recovery Bridge Housing (RBH) for people experiencing homelessness with SUD. DPH-SAPC continues to advocate for additional funding to expand.
 - Care First Community Investment: Funds interim housing, RBH, for justice involved individuals experiencing homelessness with SUD.
 - Other braided funding sources, including General Relief.
 2. State Resources
 - Project Homekey+: Provides funding to support the development of permanent supportive housing for veterans and individuals at risk of or experiencing homelessness and with mental health or substance use challenges. LA County and partnering developers have applied for the grant, including units dedicated for individuals/families with behavioral health conditions and awaiting award notifications from the State.

- Behavioral Health Bridge Housing (BHBH): Funding to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions, including serious mental illness (SMI) and/or substance use disorder (SUD). BHBH is strategically aligned with BHSA goals and directly serves BHSA-eligible populations.
- Other braided funding sources, including Assembly Bill 109 and California Work Opportunity and Responsibility to Kids.

3. Federal Resources

- Substance Abuse Prevention, Treatment, and Recovery Services Block Grant (SUBG): Funding to support SUD services directly or by contracting with local SUD providers. The SUBG Program's objective is to help plan, implement, and evaluate activities that prevent and treat SUDs. Funding can be utilized for SUD services, including RBH.
- Transitional Rent: This program will provide coverage for rent and temporary housing as a Medi-Cal service, aimed at supporting members experiencing or at risk of homelessness. SAPC will utilize this Medi-Cal benefit for RBH residents.

4. Data Sharing

- DPH-SAPC and County partners use platforms like LAHSA's Homeless Management Information System (HMIS) to coordinate care and improve housing placement targeting.

3. How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?

Many of the non-BHSA housing resources listed above are currently braided with MSHA funds and will be braided with BHSA funding and are used in coordination with the other providers and government entities. For example, DMH's interim housing will braid BHSA, CalAIM Transitional Rent and BHBH funding until BHBH ends. Clients living in interim housing and housing funding through most of BHSA funded Housing Interventions are also receiving specialty mental health services through BHSA and non-BHSA funded specialty SUD services. Also, the PSH integrated service model in Los Angeles includes BHSA funded specialty mental health services, non-BHSA funded specialty SUD services, CalAIM Tenancy Sustaining Services (TSS) and Measure A funded Intensive Case Management Services (ICMS) through the Department of Homeless Services and Housing (HSH), Client Engagement and Navigation Services (CENS) and Recovery Bridge Housing through Department of Public Health Substance Abuse Prevention and Control (DPH-SAPC) which is funded through a variety of sources. Also, PSH includes rental subsidies funded through BHSA, Measure A or Project Based Vouchers through the local Housing Authority. The SAMHSA funding for ERC is braided with BHSA and CCE funds. The HK+ funds are braided with BHSA capital and/or rental subsidies and other County and City funding for capital and/or rental subsidies. The 2011 Realignment funding for HAP is braided with BHSA and CalAIM Housing Deposits. Other areas of integration include integrated referral processes and pathways in place with other funders with similar housing types such as interim housing, ERC and PSH including the Coordinated Entry System (CES). Also DMH and DPH-SAPC will leverage HSH's Transitional Rent contracts with the Managed Care

Plans (MCPs) and their Flexible Housing Subsidy Pool (FHPS) to implement TR and Housing Deposits. HSH, DMH and DPH-SAPC are engaged in meetings with the MCPs to leverage these MediCal benefits and are establishing Memorandums of Agreement, and developing workflows for referrals, payments and other practices. DPH-SAPC is looking to strengthen integration with interim and recovery housing and establishing access to permanent supportive housing for those with SUD.

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

DMH employs a multi-pronged approach to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions. This approach includes significant investments in permanent housing resources through the local FHSP, such as licensed residential care facilities and PSH, as well as intentional efforts to identify unhoused DMH clients, develop short-and long-term housing plans, and support clients in securing appropriate housing. DMH housing resources are accessed through case managers across the system, who connect their clients to DMH-administered housing supports. DMH reinforces this process by providing trainings, a monthly Housing Liaison meeting and clear guidance on its public-facing website on available resources and how to access them.

For BHSA-funded PSH resources, DMH has made investments in: 1) the Rental Assistance Program (RAP) prioritizes individuals that are not eligible for Federal housing subsidies due to justice involvement and/or legal status; 2) Housing For Mental Health (HFMH) is allocated to specific Full Service Partnership (FSPs) programs and prioritizes individuals with high acuity needs and those that do not qualify for Federal subsidies; 3) Housing for Empowered Adult Living (HEAL) supports individuals living in licensed residential care facilities who no longer require that level of care and seek to transition into a subsidized apartments but do not qualify for Federal subsidies; 4) Homekey+ for which BHSA HI funding is used as local match to support project-based PSH rental subsidies administered by the California Housing and Community Development Department; and 5) the Housing Assistance Program (HAP) supports individuals transition from homelessness into PSH by covering security and utility deposits and providing essential household items, such as furniture.

In addition to these PH investments, DMH also administers the ERC Program, which provides rental subsidies and enhanced services rates for DMH clients residing in licensed residential care facilities who lack sufficient income to cover the full Non-Medical Out-of-Home Care (NMOHC) rate and who have complex service needs.

DMH actively participates in Los Angeles County’s CES, which is used to prioritize unhoused individuals for housing resources. Through CES, unhoused individuals are assessed to determine their level of acuity and the type of housing support needed. When PSH is indicated, case managers complete the CES assessment tool known as the Los Angeles Housing Assessment Tool (LA HAT), and enter it into the Homeless Management Information System (HMIS). Case managers also ensure clients are “document ready,” meaning required identification and Social Security documentation are uploaded into HMIS, which, in accordance with CES policy, allows clients to be placed on the CES queue.

For clients participating in DMH’s IHP, DMH requires the IHP providers to deliver housing

navigation services, develop individualized long-term housing plans, and submit monthly reports on each client's housing status. These reports include CED scores, documentation readiness, and whether the client has been matched to a PSH resource. DMH's IHP administrative team reviews these reports to confirm that clients are appropriately enrolled in CES and to support navigation to suitable PSH placements.

In addition to providing SMHS, including assistance with accessing housing through BHSA HI, DMH continues to provide SMHS services after clients are housed to support housing retention and broader recovery goals.

DPH-SAPC's strategy to promote permanent housing placement and retention for BHSA Housing Intervention participants centers on these key pillars:

1. Low-Barrier Housing Model with Behavioral Health Integration

The County ensures individuals can access housing without requiring sobriety or treatment compliance, integrating voluntary SUD treatment with housing options.

2. Cross-Agency Collaboration and Data Sharing

DPH-SAPC collaborates closely with DMH, LAHSA, DHS and Housing for Health to coordinate care and housing placements, adhering to applicable State and federal laws and regulations, including the use of HMIS.

3. Housing Navigation and Case Management

Through BHBH funding, contracted agencies assist individuals in Recovery Bridge Housing (RBH) and Recovery Housing (RH) with unit searches, landlord negotiations, lease support, and securing stable housing upon discharge.

4. Housing Retention Through Wraparound Support

Once housed, clients can continue receiving field-based behavioral health services, including outpatient SUD treatment, recovery services, and peer support to maintain housing stability.

5. Continuous Quality Improvement and Outcome Monitoring

DPH-SAPC conducts regular audits, utilizes client feedback, engages in learning collaboratives to refine housing strategies and close service gaps.

5. What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

Building on the strategies and investments described in Questions 2, 3 and 4, DMH has invested more than \$1 billion in the capital development of PSH for unhoused individuals with Serious Mental Illness (SMI) across Los Angeles County. These investments have been made through: No Place Like Home (NPLH), Special Needs Housing Program (SNHP), MHSA Housing Program, Mental Health Housing Program and the Alternative Funding Model. To date, these investments have supported 165 project-based housing developments, resulting in 4,726 PSH units ranging from studio to four-bedroom apartments. In addition, DMH provides operating subsidies in select developments through the MHSA Housing Program Capitalized Operating Subsidy Reserve (COSR), administered by the California Housing Finance Agency and through the DMH RAP program.

These housing developments are located across all eight Service Planning Areas in Los Angeles County and include dedicated units for Transition Age Youth, Older Adults,

Veterans, Adults and Families. To continue this work under the Proposition 1 Homekey+ Program, LACDMH recently committed \$30 million in Behavioral Health Services Act (BHSA) funds for capital investments, along with \$15 million a year for five years to support rental subsidies. These commitments will serve as the local match for developers seeking funding through the Homekey+ Notice of Funding Availability released by the California Department of Housing and Community Development.

All of these housing resources are matched with eligible clients through CES. DMH is a key partner in the CES system and holds a seat on the CES Policy Council, which develops policies in accordance with U.S. Department of Housing and Urban Development (HUD) requirements. DMH also collaborates closely with other PSH funders to coordinate investments, oversight, and program monitoring. DMH provides SMHS specialty mental health services to individuals residing in its PSH-funded units through its Housing Support Services Program, which is transitioning into an FSP-ICM under BHSA. These services are delivered in coordination with ICMS funded through the LA County HSH and DPH-SAPC CENS. Together, these services support residents' recovery, housing stability, and community integration. DMH meets regularly with partner County departments to oversee this integrated model and to intervene when issues arise in the PSH buildings, addressing issue that could threaten clients' housing or the overall living environment.

In addition, DMH currently maintains 11 active contracts with the two largest Public Housing Authorities in Los Angeles County, HACLA and LACDA, to administer CoC and Section 8 resources. These tenant-based resources are matched through the CES. DMH determines eligibility for all individuals matched to these subsidies, supports clients through the lease up process and provides retention services. In addition, DMH has a seat on the CoC Board and works closely with LAHSA, which administers the nation's largest CoC.

DPH-SAPC is actively engaged in multiple strategies to connect BHSA-eligible individuals—especially those with SUD and experiencing homelessness—to permanent supportive housing (PSH) and services. These efforts are grounded in partnerships across County agencies and community-based providers and are designed to address both clinical and housing stability needs.

1. Connection to PSH and Housing Navigation

- DPH-SAPC contracted providers offer housing navigation services to clients in Recovery Bridge Housing (RBH) and Recovery Housing (RH), including support with accessing the Coordinated Entry System and linkage to permanent housing settings, including connection to rental subsidies through housing authorities and partner agencies.

2. Supportive Services for Individuals in Permanent Housing

- DPH-SAPC funds ongoing outpatient SUD treatment and recovery support services that can follow clients into permanent housing through field-based services. Services include counseling, care coordination, relapse prevention, and benefits assistance, supporting both recovery and housing retention.
- DPH-SAPC partners with PSH providers to deliver onsite SUD services where needed and commits provider capacity to support residents long-term. This ensures continuity of care and wraparound services that promote housing stability for BHSA-eligible individuals.

These efforts are part of a broader cross-agency strategy to integrate behavioral health

treatment and housing supports for vulnerable populations.

6. Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services.

DMH response:

- a. DMH implements the Housing First Model in its housing programs. Most clients referred to BHSA HI settings are already actively receiving outpatient SMHS. For those who are not, DMH actively connects them to SMHS to ensure they have the supports necessary to manage their SMI and achieve housing stability. To facilitate access, services are often provided on-site or through field-based outreach. To ensure consistent access to clinical and supportive behavioral health care and housing services across all HI, DMH will implement the following measures:
- b. Provide programmatic guidelines and housing program guidelines that include information about the supportive services DMH providers are expected to offer clients accessing BHSA HI. This includes clear Program Service Exhibits that specify the behavioral health and housing support they will provide, staff roles, processes to assist clients with accessing housing, how payments are made, guidelines and procedures on how onsite and clinical staff are providing services to clients, and requirements for home visits to clients, policies on warm handoff and collaboration parameters with other service providers to clients including those provided by the MCPs service providers for Enhanced Care Management and Community Supports.
- c. Provide clients and DMH providers information about how to access care on a 24-hour basis.
- d. Conduct integrated care planning to share information while protecting client's health information.
- e. Provide Technical Assistance to housing operators to ensure compliance with BHSA regulations, and offer guidance to landlords and clients on strategies to promote housing stability and retention.
- f. Conduct Quality Assurance to monitor performance and implement corrective actions as needed.

DPH-SAPC response:

DPH-SAPC is committed to ensuring that all housing intervention settings—whether interim or permanent—offer timely, coordinated access to clinical SUD treatment and supportive behavioral health and housing services. This is achieved through a multi-layered approach that integrates field-based service delivery, cross-departmental collaboration, and system navigation support. DPH-SAPC employs a field-based model to bring outpatient SUD treatment and support services directly into housing settings. These services include outreach, engagement, referral to treatment, and interventions for individuals at risk of relapse or overdose. In collaboration with the Department of Health Services (DHS) and Department of Mental Health (DMH), DPH-SAPC works to ensure wraparound care is available within both permanent supportive housing and interim housing environments. Housing Navigators play a key role in this system, helping clients in Recovery Bridge Housing (RBH) and Recovery Housing (RH) connect to long-term housing and essential behavioral health services. Additionally, DPH-SAPC provides training and technical assistance to contracted housing providers to strengthen their capacity to respond to behavioral health needs. Topics include harm reduction, overdose response, trauma-

informed care, and recovery-oriented housing practices. These trainings are available to SAPC providers, other County departments, and community partners.

Eligible Populations

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

DMH primarily relies on its network of providers to identify, screen and refer individuals eligible for BHSA HI. In addition, DMH collaborates with many other homeless service system partners across the County to identify individuals who are unhoused and who may have an SMI. Approximately 40% of the individuals that DMH houses with SMI also have a dual diagnosis. DMH provides several access points for SMHS including the following:

- a. The DMH public-facing website includes an interactive provider directory. <https://dmh.lacounty.gov/pd/>
- b. The 24/7 Los Angeles County Helpline for Mental Health and Substance Use Services: A toll-free, 24/7 call center with trained professionals to screen and link callers to appropriate SUD treatment agencies.
- c. Universal Application Portal. Initially developed for City of Los Angeles homeless outreach workers to refer their clients to DMH, this portal has expanded to include other homeless service providers, county and city partners. Managed Care Plans can use this Universal Application Form to identify individuals that may be BHSA eligible
- d. All referrals are triaged to determine BHSA eligibility and to determine the appropriate level of care. Eligible clients are referred to the appropriate program, typically an FSP, which are field-based. DMH service providers then outreach the client, engage them in SMHS, assess both treatment and housing needs, and support them in accessing appropriate housing.
- e. DMH has Homeless Outreach and Engagement (HOME) Teams: Serve those with the most acute needs who are unhoused and have SMI, providing outreach and engagement and housing support. DMH also has other specialized outreach teams that focus on the unhoused population, including the Care Act teams, Veteran and Military Family Services, Library Engagement and Access Programs, Skid Row Concierge, Hollywood 2.0, Interim Housing Outreach Program and Re-Entry programs that conduct outreach to the unhoused population to assess BHSA eligibility and housing needs.
- f. For all referrals to BHSA HI funded housing resources, DMH's Housing Division confirms BHSA eligibility, including tracking homeless status to ensure 50% of the funding serves individuals who meet chronic homeless criteria. The DMH Housing Division will also follow workflows to refer clients to housing interventions funded through other MediCal including Community Supports Transitional Rent and the Housing Trio prior to utilizing BHSA HI funds. This process will require significant updates to referral forms, workflows and database systems.

DPH-SAPC plays a key role in ensuring that individuals with substance use disorders who are experiencing or at risk of homelessness are connected to appropriate housing resources through housing navigation and participant assistance funds. Individuals are also connected to SUD treatment resources, according to need and recommended level of care (e.g., outpatient, withdrawal management, residential services). Identification, screening, and referral of individuals eligible for BHSA Housing Interventions and supportive services will occur at all SUD service access points including:

- The 24/7 Los Angeles County Helpline for Mental Health and Substance Use Services: A toll-free, 24/7 call center with trained professionals to screen and link callers to appropriate SUD treatment agencies.
- Client Engagement and Navigation Services (CENS): In-person staff that can perform SUD outreach, engagement, screenings, linkages to treatment and ancillary services, including housing interventions, and at at-risk interventions.
- Direct SUD provider: Individuals can access SUD treatment by contacting an agency directly. All treatment agencies can identify, screen, and refer individuals eligible for Housing Interventions.

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

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

a. **In, or at-risk of being in, the juvenile justice system:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of eligible children and youth in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals in, or at risk of being in, the juvenile justice system.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized second forum on October 17, 2025, 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals in, or at risk of being in, the juvenile justice system. At the BHSA CPT meeting on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained additional input on Housing Interventions sections for the BHSA Integrated Plan.

The fourth step consisted of sharing the entire draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026, to obtain additional feedback prior to the 30-day posting period and public hearing.

- b. **Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of eligible children and youth in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing LGBTQ+ individuals.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized second forum on October 17, 2025, 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of LGBTQ+ individuals. At the BHSA CPT meeting on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained additional input on Housing Interventions sections for the BHSA Integrated Plan.

The fourth step consisted of sharing the entire draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026, to obtain additional feedback prior to the 30-day posting period and public hearing.

- c. **In the child welfare system:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of eligible children and youth in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals in the child welfare system.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized second forum on October 17, 2025, 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals in the child welfare system. At the BHSA CPT meeting on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained additional input on Housing Interventions sections for the BHSA Integrated Plan.

The fourth step consisted of sharing the entire draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026, to obtain additional feedback prior to the 30-day posting period and public hearing.

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

- a. **Older adults:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of older adults, individuals in, or at risk of being in, the justice system, and individuals from underserved communities in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing older adults.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized an interactive, participatory session on October 17, 2025, from 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of older adults. Moreover, on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained input on additional sections on Housing Interventions.

The fourth step was to share the draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026. Additional feedback will be obtained during the 30-day posting period and public hearing.

- b. **In, or are at risk of being in, the justice system:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of older adults, individuals in, or at risk of being in, the justice system, and individuals from underserved communities in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals in, or at risk of being, in the justice system.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized an interactive, participatory session on October 17, 2025, from 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals in, or at risk of being, in the justice system. Moreover, on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained input on additional sections on Housing Interventions.

The fourth step was to share the draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026. Additional feedback will be obtained during the 30-day posting period and public hearing.

- c. **In underserved communities:** The County implemented a four-step process to engage diverse community stakeholders to consider the unique needs of older adults, individuals in, or at risk of being in, the justice system, and individuals from underserved communities in the development of the County's Housing Interventions.

The first step was to form a multi-stakeholder community planning team (BHSA CPT) to provide input and feedback for the BHSA Integrated Plan (BHSA IP). With over 130 members, the BHSA CPT included stakeholder groups representing individuals from underserved communities.

The second step was to engage the BHSA CPT members to identify unmet housing needs and housing service gaps. After reviewing the components of the local behavioral health continuum of care on April 8, 2025, BHSA CPT members

participants identified unmet needs and service gaps with regards to Housing Interventions at its meetings on April 25 and May 13, 2025. On July 8, 2025, BHSA CPT members reviewed DHCS' data on disparities regarding homelessness in Los Angeles County, highlighted factors driving these disparities, and identified potential solutions.

The third step was to solicit specific input on BHSA Housing Interventions through two interlocking forums for BHSA CPT members and other community stakeholders. At the first forum, on September 29, 2025, from 1-4 PM, the County provided an overview of the local landscape of housing resources and policies, including Measure A, the housing benefits linked to managed care plans, mental health and SUD services for people experiencing homeless, and BHSA regulations for Housing Interventions.

With this foundational information in place, the County organized an interactive, participatory session on October 17, 2025, from 9:30-12:30, to solicit input on key sections of the BHSA Housing Interventions section. During this forum, small group discussions were held focused on the specific needs of individuals from underserved communities. Moreover, on November 18, 2025, the County shared a summary of stakeholder input from the Housing Interventions forums, provided an overview of Housing Interventions, and obtained input on additional sections on Housing Interventions.

The fourth step was to share the draft section of the BHSA IP's Housing Interventions at the BHSA CPT Forum on January 20, 2026. Additional feedback will be obtained during the 30-day posting period and public hearing.

Local Housing System Engagement

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

DMH has a long history of working with the four CoCs in Los Angeles County, which include Long Beach, Pasadena, Glendale and Los Angeles and receiving referrals through CES for housing. All four CoCs participate on the CES Policy Council alongside DMH, where they collaborate to develop CES policies. Among the four, LAHSA, a joint powers authority of the City and County of Los Angeles, is the largest and serves as the CES lead. LAHSA is responsible for managing the CES queue and providing matches for most PSH resources. DMH works closely with LAHSA and HSH to coordinate homeless system services, including interim housing, outreach and PSH. In addition to receiving CES referrals from the CoC, DMH receives referrals from other system partners including HSH. DMH participates in numerous regular coordination meetings with system partners to align resources and maximize utilization of housing resource, address system challenges and problem solving, and minimize duplication of efforts. These meetings include Housing Central Command, Service System Partners, and Interim Housing Partner Monthly meetings.

Regarding Interim Housing referrals, DMH conducts daily Air Traffic Control (ATC) meetings with LAHSA and HSH to help navigate unhoused individuals to the appropriate interim or other housing resource. DMH also holds a Skid Row-focused ATC, including the co-location of staff a few days a week at the Skid Row Care Campus to coordinate referrals. Staff are additionally co-located at the Emergency Centralized Response Center to assist with outreach and direct unhoused people to housing resources, including DMH's BHSA HI.

DMH also operates some MHSA-funded PSH projects with project-based vouchers in Long Beach, for which referrals are received through the Long Beach CES system. Currently, DMH does not have PSH projects in Pasadena or Glendale; however, DMH is actively working with the City of Pasadena to secure permits for a new Interim Housing site in Pasadena.

DPH-SAPC maintains strong and ongoing coordination with the Los Angeles CoC, currently administered by the Los Angeles Homeless Services Authority (LAHSA).

Coordinated Entry System (CES) Integration

DPH-SAPC contracted providers are trained to conduct CES assessments, complete housing documentation, and refer clients with SUD—especially those experiencing or at risk of homelessness—into CES for housing placement.

Bidirectional Referral Flow

Referrals occur in both directions. Clients in DPH-SAPC services are connected to CES for housing navigation, while individuals identified through CES or LAHSA outreach who present with SUD needs are referred to DPH-SAPC for screening and linkage to BHSA-eligible services.

Data Integration and Tracking

DPH-SAPC utilizes the Homeless Management Information System (HMIS) with appropriate data-sharing authorizations to track referrals, placements, and outcomes in coordination with LAHSA and CoC partners.

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

- a. **Local CoC:** As outlined in Question 3 above, DMH has strong collaborative partnerships with the four local CoCs and provided several examples illustrating our partnerships. In addition, DMH uses HMIS which is managed by LAHSA and is also used by the other three CoCs to look up client information and to enter interim housing, BHBH, CoC and No Place Like Home data to meet the AB 977 requirements. As required by BHSA, DMH will expand its use of HMIS. Discussions are already underway with LAHSA regarding meeting these new requirements to include all required BHSA HI information in HMIS. DMH’s Chief Information Office (CIO) has led conversations with LAHSA about developing data system interoperability for data sharing and necessary MOUs. While these efforts will require significant coordination, they are particularly challenging given the recent changes in Los Angeles County, including the County removing most of their funds from LAHSA and the Federal CoC changes by HUD. Despite these challenges, DMH remains committed to ensuring data integration and compliance to support BHSA HI.
- b. **Public Housing Agency:** DMH currently holds 11 active contracts with the two largest PHAs in Los Angeles County, HACLA and LACDA, some of which date back to the 1990’s. DMH’s Housing Division’s Federal Housing Subsidy Unit (FHSU) collaborates daily with HACLA and LACDA to administer these contracts, which provide subsidies to DMH clients. Potential clients are matched to these resources through CES, and DMH

- confirms eligibility. DMH or ICSM case managers assist clients in completing housing applications. FHSU oversees contract administration, including reviewing the applications for completeness, submitting them to the PHAs, responding to requests from the PHAs for corrections or additional information, tracking application and following up on delays. FHSU also ensures case managers support clients through the lease-up process and continue to provide SMHS after lease-up. In addition, FHSU gathers and meets all PHA/HUD data and reporting requirements and advocates with the PHAs on behalf of our clients to ensure housing retention. DMH maintains ongoing collaboration with the PHAs through participation in key governing bodies such as the CoC Board, CES Policy Council, and Housing Central Command.
- c. **MCPs:** DMH has data sharing agreements with six of the eight MCPs in LA County and is currently working with the MCPs and intercounty agencies to develop workflows for TR, HD, and BHSA HI. These efforts include identifying necessary updates to data sharing agreements to establish workflows and ensure bi-directional data exchange is in place to support member transitions and housing services. Rather than contracting directly with the MCPs to provide CalAIM Community Supports TR and HD, DPH-SAPC and DMH will partner with the County Department of HSH through a Memorandum of Understanding. This partnership leverages HSH's existing contracts with the MCPs as well as their workflows, policies and procedures, claiming system and payment and reimbursement procedures.
 - d. **ECM and Community Supports Providers:** DMH has contracts with four MCPs to provide ECM services. For clients served by DMH with BHSA or other funding that are also receiving ECM or Community Supports services from other providers, DMH will work with them to coordinate care. Our data sharing agreements with the MCPs include data elements that will assist us with identifying who is receiving ECM and/or Community Supports services and the name and contact information of the service provider.
 - e. **Other (e.g., CalWORKs/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.):**
 - i. DMH collaborates with a variety of partners to ensure clients have access to housing resources managed by other entities to which they are entitled or eligible. For example, DMH coordinates with the Department of Public Social Services, which manages housing funds for CalWORKs and General Relief participants, to ensure DMH clients can utilize these resources. Similarly, DMH works with the Department of Children and Family Services (DCFS) to support the child welfare population in accessing services not covered by Medi-Cal, including housing assistance. DMH also assists disconnected former foster youth to help them access housing through DCFS housing programs, such as the Independent Living Program, while providing necessary mental health supports.
 - ii. Since 2008, DMH has invested over \$1 billion for the capital development of PSH and maintains MOUs with 49 different PSH developers, representing approximately 4,716 units that target unhoused individuals with SMI. DMH works closely with other funders of PSH such as the Los Angeles Housing Department and various homeless service providers, many of whom are funded through the County's Measure A tax.

5. How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that

support and house BHSA eligible individuals?

DMH response:

As noted above, since 2008, over \$1 billion in MHSA funding has been committed in LA County for the capital development of PSH through programs such as the MHSA Housing Program and No Place Like Home. Each development fills its units using the CES, and DMH has established processes to ensure our unhoused clients are included on the CES Community Queue. For example, DMH's Housing Division's Referral, Access and Data (RAD) team works with DMH housing leads in each SPA to identify unhoused clients and submit their names to LAHSA. DMH's RAD team also confirms the eligibility of the tenants that are matched to MHSA-funded PSH units and DMH offers/provides specialty mental health services to eligible tenants.

DMH has led the County's efforts to implement HK+ in partnership with other County Departments including HSH, Department of Military and Veteran Affairs and the LACDA, which is the lead HK+ applicant on behalf of the County. DMH committed \$30 million of MHSA/BHSA funds for capital match and \$15 million each year for five (5) years for rental subsidies, which were allocated through various solicitation processes to award eligible projects. DMH contracted with Le Sar Development Consultants to support our implementation HK+. In addition, DMH wrote letters of support for all HK+ projects in Los Angeles County including those in which other jurisdictions, such as the City of LA, were the lead applicant. In the letters of support, DMH also provided a commitment to provide SMHS for eligible tenants. CES will be used to fill the HK+ units and DMH's RAD team will verify the eligibility of all clients that move into HK+ assisted units and identify a SMHS provider.

DPH-SAPC response:

DPH-SAPC will provide rental subsidies and participate in DHS's Flexible Housing Subsidy Pool (FHSP). In addition, supportive services will be provided by contracted SUD treatment providers who will deliver onsite and field-based services tailored to support long-term tenancy and behavioral health stabilization. DPH-SAPC will align its treatment and recovery services with supportive housing operations by leveraging Drug Medi-Cal (DMC-ODS) and coordinating with Medi-Cal Managed Care Plans to connect individuals to Community Supports. DPH-SAPC also works closely with LAHSA, DHS, DMH, LACDA, and the CEO's office to ensure service delivery is integrated into new housing developments. These planning efforts emphasize client-centered care, cross-system coordination, and data-informed decision-making to support housing retention and recovery for BHSA-eligible individuals.

6. Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding? No

BHSA Housing Interventions Implementation

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

Rental Subsidies (Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent

settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

1. **Is the county providing this intervention? Yes**

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

Yes

3. **How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis? 5,699¹**

¹Approximately 5,699 of individuals are expected to be served with rental subsidies. This includes 4,480 served with bundled rental and operating subsidies and 1,219 served with only rental subsidies. Since the budget template has a bundled rental and operating subsidy category and the BHSA Integrated Plan (IP) does not, those receiving bundled subsidies are included in the rental subsidy and operating subsidy sections. Although this results in duplicated data, they are clearly indicated as such. These numbers also reflect only those individuals expected to be served in FY 2026-27 and do not reflect additional clients that we anticipate serving in FY 2027-28 and FY 2028-29 once certain categorical funding sources end. Those estimates of clients served will be in future BHSA IPs

a. **How many of these individuals will receive rental subsidies for permanent housing on an annual basis? 3,418¹**

¹Approximately 3,418 of the 5,699 individuals will receive rental subsidies for permanent housing. This includes 2,231 served with bundled rental and operating subsidies and 1,187 served with only rental subsidies.

b. **How many of these individuals will receive rental subsidies for interim housing on an annual basis? 2,731¹**

¹Approximately 2,281 of the 5,699 individuals will receive rental subsidies for interim housing. This includes 2,249 served with bundled rental and operating subsidies and 32 served with only rental subsidies. SAPC: 450 subsidies for individuals with SUD for RBH + RH

4. **What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?**

To estimate the total number of individuals expected to be served with rental subsidies, DMH first calculates the total number of dedicated units/beds for each housing program. Using the average annual retention rate for each housing type, DMH then estimates the number of additional clients anticipated to be served due to turnover and adds this number to the number of dedicated units/beds.

Programs are classified as either providing interim or permanent housing, with interim housing including DMH's interim Housing, Emergency Enhanced Shelter Program, motels and short-term rental assistance. Permanent housing includes DMH's Enriched Residential Care (ERC) program, which provides rental and operating subsidies for licensed residential care facilities and project-based/tenant-based permanent supportive housing through DMH's Rental Assistance Program (RAP), Housing For Mental Health Program (HFMH) and Housing for Empowered Adult Living (HEAL). This classification was then used to determine the total number of individuals served in interim and permanent settings.

BHSA Housing Intervention funding for DPH-SAPC will support approximately 450 Recovery Bridge Housing and Recovery Housing beds when the BHBH grant sunsets in June 2027.

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

- Non-Time-Limited Permanent Settings: Supportive housing
- Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
- Non-Time-Limited Permanent Settings: Shared housing
- Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including

recovery-oriented housing

- Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care
- 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) (does not include behavioral residential treatment settings)
- Time-Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
- Time-Limited Interim Settings: Other settings identified under the Transitional Rent benefit

6. Will this Housing Intervention accommodate family housing? Yes

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

- a. DMH has four programs funded through BHSA HI: Rental Assistance, ERC, RAP, HFMH and HEAL. These programs provide tenant-based and project-based rental subsidies to clients that are homeless, chronically homeless or at risk of homelessness. RAP, HFMH, and HEAL provide rental subsidies in PSH and make housing affordable for those with extremely low or no income. The client portion of the rent is 30% of their income and the subsidy pays the balance of the rent using Housing Urban Development's Fair Market Rent (FMR). These subsidies are available for DMH clients receiving SMHS, prioritizing those with SMI that are not eligible for Federal Subsidies due to legal status, criminal convictions or otherwise deemed ineligible by the PHA.
- b. The ERC program provides subsidies equivalent to the NMOHC rate, including personal and incidental funds, for individuals with no income residing in licensed residential care facilities. The ERC program also provides enhanced services operating subsidies based on the needs of the client using a tiered-rate system. The funding for these programs are managed through a local Flexible Housing Subsidy Pool (FHSP) and are administered by Brilliant Corners (BC), a third-party administrator. All referrals are submitted by case managers to DMH's Housing Division which reviews referrals for appropriateness and compliance with BHSA homeless criteria and that 50% of the funds are used on those that are chronically homeless. Individuals who are in encampments will be prioritized.
- c. For those that are approved for a DMH RAP subsidy, the case manager will submit a FHSP application, which is reviewed by BC to ensure income and other eligibility is met. BC has a unit acquisition department, which can assist with unit acquisition or the case manager/client will locate a unit. For PSH, BC ensures the unit rent meets the FMR standard and will enter into an agreement with the landlord to make payments. BC will calculate both the client's portion of the rent and the BHSA-funded subsidy. The BC subsidy will be paid directly to the landlord each month, and BC will serve as the primary contact for the landlord regarding any tenant-related concerns, notifying DMH to follow up as needed.
- d. DPH-SAPC: Project Homekey+ provides funding to support the development of permanent supportive housing for individuals at risk of or experiencing homelessness

and with mental health or substance use challenges. LA County and partnering developers have applied for the grant, including units dedicated for families with behavioral health conditions and awaiting award notifications from the State. The HK+ funds are braided with BHSA capital and/or rental subsidies and other County and City funding for capital and/or rental subsidies. SAPC's PSH services also include rental subsidies funded through BHSA, Measure A or Project Based Vouchers through the local Housing Authority. SAPC will also provide rental subsidies and participate in DHS's Flexible Housing Subsidy Pool (FHSP).

8. Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

a. **Project-based:** Yes

b. **Tenant-based:** Yes

9. How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in

a. DMH has several ways it identifies a portfolio of available units to assist BHSA-eligible clients to secure housing. As mentioned above, our third party administrator, BC, manages the FHSP and has an unit acquisition team that proactively outreaches to landlords to secure units for clients accessing FHSP funds, including DMH clients. For BHSA eligible individuals that have PHA issued vouchers, they use the PHA's list of landlords that are interested in accepting Section 8. DMH SMHS provider also assists their clients with identifying units/beds in partnership with the clients. Many case managers have an expertise in housing navigation and long-standing relationships with landlords that lease to DMH clients and the landlords notify them of vacancies.

b. Approximately 260 of DMH's RAP subsidies are in project-based buildings, which will increase when HK+-funded buildings are ready for occupancy. DMH partners with LAHSA and HSH which have funding to master lease or similarly secure units that target individuals with tenant-based subsidies. These units are listed in a portal called Padmission, which can be accessed by partnering providers. For the ERC beds, DMH has an ERC provider directory on its public-facing website to assist case managers with locating licensed residential care facilities. Finally, DMH's significant investments in capital development of PSH comprise 165 PSH project-based buildings with 4,726 PSH units dedicated to DMH clients.

10. Total number of units funded with BHSA Housing Interventions per year: 4,510¹

¹Approximately 4,060 housing resources will be funded with BHSA Housing Interventions rental subsidies per year. This includes 1,322 dedicated beds/units and 2,738 rental subsidies. Due to the inclusion of those receiving bundled subsidies, there is overlap between this and the housing resource count for operating subsidies. DPH-SAPC Response: 450 units for RBH + RH beginning FY '27-28.

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

The County operates several in which the number of individuals served is determined by available funding rather than by contracted beds or dedicated units. Examples include the ERC Program, where participants have the freedom to use their subsidy at any eligible licensed residential care facility, as well as the RAP, HEAL and HFMH, which provides tenant-based local subsidies to eligible individuals.

DPH-SAPC Response: BHSA funding will continue to support SAPC Housing Navigation services upon BHBH sunsetting.

Operating Subsidies (Chapter 7, Section C.9.2)

1. **Is the county providing this intervention? Yes**
2. **Is the county providing this intervention to chronically homeless individuals? Yes**
3. **Anticipated number of individuals served per year: 4,593¹**

¹Approximately 4,593 individuals are expected to be served with operating subsidies. This includes 4,480 served with bundled rental and operating subsidies and 113 served with only operating subsidies. Due to the inclusion of those receiving bundled subsidies, there is overlap between this and the rental subsidies count. These numbers also reflect only those individuals expected to be served in FY 2026-27 and do not reflect additional clients that we anticipate serving in FY 2027-28 and FY 2028-29 once certain categorical funding sources end.

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

a. Bundled rental and operating subsidies will be used for interim housing, which is funded through a daily bed rate. Given the requirement to use CalAIM TR, which only pays for the rent and utilities, DMH is separating the interim housing bed rates into a bundled rate, made up of a rental and operating subsidy. The operating subsidy portion of the bed rate will include all Interim Housing costs other than the rent/mortgage and utilities, including program supplies such as furniture, linens, food, vehicle costs, parking, office supplies; and client supports such as clothing, transportation, program activities; staffing including employee benefits and administrative staff and operating overhead.

b. A bundled rental and operation subsidy will also be used for DMH's Enriched Residential Care (ERC) program. ERC provides rental subsidies to individuals without an income to pay the NMOHC rate and an enhanced services operating subsidy to cover the operating expenses specific to the complex needs of the client, which is determined through a four-tier system. Operating expenses can include additional staff and supplies needed to support the client's needs.

5. **For which setting types will the county provide operating subsidies? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter ([Chapter 7, Section C.9.3 Allowable Settings](#))]**

- Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care
- 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) (does not include behavioral residential treatment settings)
- Time-Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

6. **Will this be a scattered site initiative? Yes**
7. **Will this Housing Intervention accommodate family housing? Yes**
8. **Total number of units funded with BHSA Housing Interventions per year: 2,953¹**

¹Approximately 2,953 housing resources will be funded with BHSA Housing Interventions operating subsidies per year. This includes 1,042 beds/units and 1,911 operating subsidies. Due to the inclusion of those receiving bundled subsidies, there is overlap between this and the housing resource count for rental subsidies.

9. **[Optional question] Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a**

specific number of units

DMH's ERC program includes one project-based site – the Crocker Care Campus ERC—an RCFE with 24 DMH-dedicated beds. All other ERC funding for bundled rental and operating subsidies is not tied to specific beds but is used in a scattered-site model, covering the NMOHC rate and an enhanced services rate for clients in any licensed residential care bed that will accept the client.

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

- 1. Is the county providing this intervention? Yes**
 - 2. Is the county providing this intervention to chronically homeless individuals? Yes**
 - 3. Anticipated number of individuals served per year: 1,608¹**
- 4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

¹ Approximately 1,608 individuals will be served per year through landlord outreach and mitigation funds.

DMH has operated the Housing Assistance Program (HAP) for many years, funded through multiple funding sources including BHSA. This program provides support for housing and utility deposits, household goods, and prevention. In addition, DMH administers other rental assistance programs through the FHSP, such as HFMH, HEAL, and RAP which also include support for security and utility deposits, household goods and damage mitigation. Based on stakeholder feedback, under BHSA, DMH plans to expand the funding and allowable uses under HAP by including the following Landlord Outreach and Mitigation Funds categories: holding fees, damage reimbursement outside of normal wear and tear and eviction prevention which includes financial assistance, back-rent, mediation, tenant education, legal costs and connection to resources. There has been a well-documented need for funding for damage reimbursement outside of usual wear and tear by the Supportive Housing Alliance which has membership from non-profit developers of PSH for many years. DMH has frequently been approached by developers' request to pay for damages caused by DMH clients but DMH has not had funding allocated for this purpose. The supportive housing alliance surveyed their members, and they reported that the average cost of damages from DMH tenants on a per unit/per year basis over a three-year period was \$7,132.

- 5. Total number of units funded with BHSA Housing Interventions per year: 1,608¹**
 - 6. [Optional question] Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units: N/A**
- ¹ Approximately 1,608 units will be funded per year through landlord outreach and mitigation funds.

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

- 1. Is the county providing this intervention? Yes**
 - 2. Is the county providing this intervention to chronically homeless individuals? Yes**
 - 3. Anticipated number of individuals served per year: 5,558¹**
- ¹ Approximately 1,558 individuals will be served per year through participant assistance funds. DPH-SAPC responded with approximately 4,000.
- 4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

DMH has operated the Housing Assistance Program (HAP) for many years, funded through multiple funding sources including BHSA. This program provides support for housing and utility deposits, household goods, and eviction prevention. Under BHSA, DMH will now need to update workflows to include accessing CalAIM Community Supports Housing Deposits funding for eligible clients prior to using this funding. In addition, under BHSA—and with strong support from DMH stakeholders—DMH plans to expand the funding and allowable uses under HAP to include all of the allowable uses under Participant Assistance Funds. This will allow us to add categories of funding including those related to obtaining government-issued identification and other vital documents required to obtain housing, housing application fees, fees for credit reports, storage fees, pet deposits, transportation, food and hygiene products.

DPH-SAPC response: Participant Assistance Funds (PAF) are available through Los Angeles County's Housing Navigation program, in an effort to connect individuals with substance use disorders to housing opportunities and supportive services. While PAF is currently funded through BHBH, funding through BHSA Housing Interventions would be needed to sustain the service. PAF serves as a complementary resource that supports BHSA-eligible individuals by addressing immediate housing-related barriers that cannot be met through other funding streams.

Uses of PAF to support BHSA-eligible individuals include:

- Application and administrative fees for housing (e.g., credit checks, background checks)
- Security deposits and utility deposits (when no other source is available)
- Short-term motel stays to bridge to a more stable housing placement
- Transportation assistance to housing appointments or move-ins
- Basic furnishings and household supplies needed for move-in
- Moving and storage costs, including costs that would otherwise delay housing access

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

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

1. **Is the county providing this intervention? Yes**
2. **Is the county providing this intervention to chronically homeless individuals? Yes**
3. **Anticipated number of individuals served per year: 5,684¹**
¹Anticipated number of individuals served per year [numeric response] Currently, DMH funds Intensive Case Management Services (ICMS) through HSH for DMH clients living in 1,124 PSH units through an MOU with HSH. An additional 560 clients are funded through an MOU with Department of Health Services Office of Diversion and Re-Entry. HSH claims these services to the MCPs under CalAIM Community Supports TSS. However, due to reconciliation difficulties with the MCPs over the past three years, the number of clients that we would expect to be funded through the MCPs is unknown. Under BHSA, DMH will continue to work with HSH to ensure CalAIM Community Supports for TSS is claimed prior to providing these services through BHSA and to reconcile the claims. DPH-SAPC response, approximately 4,000.
4. **Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding**

ICMS services include housing supports necessary to assist clients with retaining their housing including life skills training, assistance with establishing benefits and securing employment, assessing legal needs and referring for legal assistance, assessing client service needs and referring to appropriate service providers such as mental health,

physical health and substance use disorder services, adjusting with activities of daily living, providing transportation, supporting community connections and providing other housing retention services such as working with property management to resolve issues that threaten housing stability.

DPH-SAPC response: DPH-SAPC provides Housing Navigation Services to individuals in Recovery Bridge Housing (RBH) and Recovery Housing (RH) who are transitioning to permanent housing. This service is funded by BHBH and BHSA funding is needed to sustain these services beyond the BHBH grant, particularly for individuals not eligible for housing transition services through their Medi-Cal Managed Care Plan (MCP).

These services are primarily delivered by Housing Navigators, who assist individuals with substance use disorders, many of whom are chronically homeless or at risk of homelessness, with navigating the housing system and securing stable placements. Activities include identifying housing options, assembling required documentation (e.g., ID, income verification), coordinating transportation for housing-related appointments, and facilitating communication with landlords and housing agencies.

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

1. **Is the county providing this intervention?** No
 - a. **Please explain why the county is not providing this intervention**
Outreach and engagement will be funded under Full Service Partnership.

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

1. **Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?** Yes
2. **Is the county providing this intervention to chronically homeless individuals?** Yes
3. **How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?** 16¹

¹DMH has committed \$30 million of capital development funding as capital match for HK+ PSH. None of the HK+ applications submitted to the California Housing and Community Development (HCD) Department have been approved.

Capital Development Project Specific Information

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

1. **Name of Project #1:** Daimaru Hotel
2. **What setting types will the capital development project include?** Non-Time Limited
Permanent Settings: Supportive housing
3. **Capacity (Anticipated number of individuals housed at a given time)** 10
4. **Will this project braid funding with non-BHSA funding source(s)?** Yes
5. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 26
6. **Total number of units funded with Housing Interventions funds only:** 10
7. **Anticipated date of unit availability:** 04/01/2027
8. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000)** \$475,479 per unit, BHSA portion: \$100,000
9. **Have you utilized the “by right” provisions of state law in your project?** No

- a. **If you have not incorporated use of the “by right” provisions into your project, please explain why:** The project will not trigger discretionary entitlements like Site Plan Review because there is no increase in floor area and the use remains residential. The project will be an Affordable Housing Project as defined by the Los Angeles Housing Department with reference to CA H&SC 50079.5, 50105, and 50106 therefore is exempted from the City of LA's SRO Ordinance.
10. **Name of Project #2:** Huntington Villas
 11. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
 12. **Capacity (Anticipated number of individuals housed at a given time)** 52
 13. **Will this project braid funding with non-BHSA funding source(s)?** Yes
 14. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 53
 15. **Total number of units funded with Housing Interventions funds only:** 52
 16. **Anticipated date of unit availability:** Unknown at this time
 17. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000)** \$392,453
 18. **Have you utilized the “by right” provisions of state law in your project?** Unsure due to LA City jurisdiction
 - a. **If you have not incorporated use of the “by right” provisions into your project, please explain why:** N/A
 19. **Name of Project #3:** Casa Bella
 20. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
 21. **Capacity (Anticipated number of individuals housed at a given time)** 62
 22. **Will this project braid funding with non-BHSA funding source(s)?** Yes
 23. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 62
 24. **Total number of units funded with Housing Interventions funds only:** 61
 25. **Anticipated date of unit availability:** 05/01/2027
 26. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000)** \$424,804, BHSA portion: \$121,311
 27. **Have you utilized the “by right” provisions of state law in your project?** No
 - a. **If you have not incorporated use of the “by right” provisions into your project, please explain why:** The conversion from hotel to permanent supportive housing will be reviewed ministerially.
 28. **Name of Project #4:** St. Vincent Supportive Community
 29. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Supportive housing
 30. **Capacity (Anticipated number of individuals housed at a given time)** 170
 31. **Will this project braid funding with non-BHSA funding source(s)?** Yes
 32. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 172
 33. **Total number of units funded with Housing Interventions funds only:** 170
 34. **Anticipated date of unit availability:** 04/01/2027
 35. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the**

- project must be equal to or less than \$450,000) \$495,582, BHSA portion: \$91,465
36. **Have you utilized the “by right” provisions of state law in your project?** No
- a. **If you have not incorporated use of the “by right” provisions into your project, please explain why:** The conversion from hotel to permanent supportive housing will be reviewed ministerially.
37. **Name of Project #5:** Founders House of Hope, Inc.
38. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
39. **Capacity (Anticipated number of individuals housed at a given time):** 98
40. **Will this project braid funding with non-BHSA funding source(s)?** No
41. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 98
42. **Total number of units funded with Housing Interventions funds only:** 98
43. **Anticipated date of unit availability:** 5/1/2026
44. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
45. **Have you utilized the “by right” provisions of state law in your project?** Yes
46. **Name of Project #6:** Long Beach Residential
47. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
48. **Capacity (Anticipated number of individuals housed at a given time):** 49
49. **Will this project braid funding with non-BHSA funding source(s)?** No
50. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 49
51. **Total number of units funded with Housing Interventions funds only:** 49
52. **Anticipated date of unit availability:** 5/1/2026
53. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
54. **Have you utilized the “by right” provisions of state law in your project?** Yes
55. **Name of Project #7:** Fair Oaks Manor III
56. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
57. **Capacity (Anticipated number of individuals housed at a given time):** 30
58. **Will this project braid funding with non-BHSA funding source(s)?** No
59. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 30
60. **Total number of units funded with Housing Interventions funds only:** 30
61. **Anticipated date of unit availability:** 5/1/2026
62. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
63. **Have you utilized the “by right” provisions of state law in your project?** Yes
64. **Name of Project #8:** Sunnyside Retirement Center

65. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
66. **Capacity (Anticipated number of individuals housed at a given time):** 48
67. **Will this project braid funding with non-BHSA funding source(s)?** No
68. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 48
69. **Total number of units funded with Housing Interventions funds only:** 48
70. **Anticipated date of unit availability:** 5/1/2026
71. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
72. **Have you utilized the “by right” provisions of state law in your project?** Yes
73. **Name of Project #9:** The Grandview LLC
74. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
75. **Capacity (Anticipated number of individuals housed at a given time):** 215
76. **Will this project braid funding with non-BHSA funding source(s)?** No
77. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 215
78. **Total number of units funded with Housing Interventions funds only:** 215
79. **Anticipated date of unit availability:** 5/1/2026
80. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
81. **Have you utilized the “by right” provisions of state law in your project?** Yes
82. **Name of Project #10:** Beverly Hills Terrace
83. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
84. **Capacity (Anticipated number of individuals housed at a given time):** 100
85. **Will this project braid funding with non-BHSA funding source(s)?** No
86. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 100
87. **Total number of units funded with Housing Interventions funds only:** 100
88. **Anticipated date of unit availability:** 5/1/2026
89. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
90. **Have you utilized the “by right” provisions of state law in your project?** Yes
91. **Name of Project #11:** Woodruff Care Home, Inc.
92. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
93. **Capacity (Anticipated number of individuals housed at a given time):** 88
94. **Will this project braid funding with non-BHSA funding source(s)?** No
95. **Total number of units in project, inclusive of BHSA and non-BHSA funding**

sources: 88

96. **Total number of units funded with Housing Interventions funds only: 88**
97. **Anticipated date of unit availability: 5/1/2026**
98. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000): \$14,648**
99. **Have you utilized the “by right” provisions of state law in your project? Yes**
100. **Name of Project #12: Villa Stanley**
101. **What setting types will the capital development project include? Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)**
102. **Capacity (Anticipated number of individuals housed at a given time): 80**
103. **Will this project braid funding with non-BHSA funding source(s)? No**
104. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources: 80**
105. **Total number of units funded with Housing Interventions funds only: 80**
106. **Anticipated date of unit availability: 5/1/2026**
107. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000): \$14,648**
108. **Have you utilized the “by right” provisions of state law in your project? Yes**
109. **Name of Project #13: Crystal Manor Residential Care Home, LLC**
110. **What setting types will the capital development project include? Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)**
111. **Capacity (Anticipated number of individuals housed at a given time): 26**
112. **Will this project braid funding with non-BHSA funding source(s)? No**
113. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources: 26**
114. **Total number of units funded with Housing Interventions funds only: 26**
115. **Anticipated date of unit availability: 5/1/2026**
116. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000): \$14,648**
117. **Have you utilized the “by right” provisions of state law in your project? Yes**
118. **Name of Project #14: LTG Holding, Inc. Dba Gilmar Manor**
119. **What setting types will the capital development project include? Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)**
120. **Capacity (Anticipated number of individuals housed at a given time): 78**
121. **Will this project braid funding with non-BHSA funding source(s)? No**
122. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources: 78**
123. **Total number of units funded with Housing Interventions funds only: 78**
124. **Anticipated date of unit availability: 5/1/2026**
125. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000): \$14,648**
126. **Have you utilized the “by right” provisions of state law in your project? Yes**

127. **Name of Project #15:** Pasadena Adult Living Center
128. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
129. **Capacity (Anticipated number of individuals housed at a given time):** 136
130. **Will this project braid funding with non-BHSA funding source(s)?** No
131. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 136
132. **Total number of units funded with Housing Interventions funds only:** 136
133. **Anticipated date of unit availability:** 5/1/2026
134. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
135. **Have you utilized the “by right” provisions of state law in your project?** Yes
136. **Name of Project #16:** Bay Breeze Care, Inc.
137. **What setting types will the capital development project include?** Non-Time Limited Permanent Settings: Assisted Living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
138. **Capacity (Anticipated number of individuals housed at a given time):** 76
139. **Will this project braid funding with non-BHSA funding source(s)?** No
140. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources:** 76
141. **Total number of units funded with Housing Interventions funds only:** 76
142. **Anticipated date of unit availability:** 5/1/2026
143. **Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000):** \$14,648
144. **Have you utilized the “by right” provisions of state law in your project?** Yes

Housing Interventions (Optional)

1. **If the county is providing another type of Housing Interventions not listed above, please describe the intervention:**
 - a. **Is the county providing this intervention to chronically homeless individuals?**
Yes
 - b. **Anticipated number of individuals served per year:** 468

Continuation of Existing Housing Programs

1. **Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)**

DMH plans to use BHSA HI funds to continue our investments made through two State funded programs that have sunset dates, including BHBH and CCE Operating Subsidies. DMH has used BHBH to make significant investments in DMH’s interim housing program, RAP and ERC programs and is committed to continuing once the funding ends. DMH received an extension from DHCS for the BHBH program through June 30, 2029, which DMH greatly appreciates. However, this extension increases the complexity of ensuring that 30% of BHSA funds are spent on housing beginning in FY 2026-27, while maintaining BHSA HI on-going funding commitments that incorporate BHBH and CCE Operating

Subsidy Program funds (which has a sunset date of March 31, 2029) once those programs end.

DMH will also use the following Mental Health Services Act-encumbered Innovation Projects to support the interim and permanent housing components: **Hollywood 2.0 and IHOP**.

DPH-SAPC provides Housing Navigation Services to individuals in Recovery Bridge Housing (RBH) and Recovery Housing (RH) who are transitioning to permanent housing. This includes a total of approximately 450 RBH and RH beds and Housing Navigation Services to assist residents in RBH and RH transition to permanent housing settings. This service is funded by BHBH and BHSA funding is needed to sustain these services beyond the BHBH grant, particularly for individuals not eligible for housing transition services through their Medi-Cal Managed Care Plan (MCP).

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

For more information, please see [7.C.7 Relationship to Medi-Cal Funded Housing Services](#)

1. **Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?** Transitional Rent
2. **For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?**
 - a. Housing Transition Navigation Services: Undecided
 - b. Housing Deposits: No
 - c. Housing Tenancy and Sustaining Services: No
 - d. Short-Term Post-Hospitalization Housing: No
 - e. Recuperative Care: No
 - f. Day Habilitation: No
 - g. Transitional Rent: Yes, 1/1/2026, the county behavioral health system plans to become an MCP-contracted provider.
3. **How will the county behavioral health system identify, confirm eligibility, and [refer Medi-Cal members to housing-related Community Supports covered by MCPs \(including Transitional Rent\)](#)?**

Rather than contracting directly with the MCPs to be a CalAIM Community Supports TR and HD provider, DMH will partner with the Los Angeles County Department of HSH through an MOU. This partnership leverages HSH's existing contracts with the MCPs as well as their workflows, policies and procedures, claiming system and payment and reimbursement procedures. DMH has been working with HSH and the MCPs to develop workflows, forms and a common understanding of the DHCS guidance on TR. For all clients that are accessing DMH housing resources for which we are required to leverage TR or HDs, DMH will confirm through the Aves system whether the client has Medi-Cal and their MCP. A Housing Support Plan and authorization form will be developed and submitted to HSH, who will submit the authorization to the MCP. DMH is in discussions with the MCP plans and DHCS to determine the workflow for referrals to determine BHSA eligibility for individuals referred for TR that do not originate from DMH.

DPH-SAPC will coordinate referrals for Transitional Rent Community Supports with MCPs to confirm eligibility, including service authorization, time remaining for this benefit for each

eligible individual, and invoicing for this benefit. Transitional Rent will be used for eligible individuals who are residing in RBH.

4. Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

DMH plans to centralize the referral process for DMH clients accessing BHSA HI housing resources to TR and HD. DMH will pay for the housing while waiting for MCP authorization approval and payment and will then reconcile on the back end. DMH intends to make this a seamless process for the BHSA HI housing network and as such the payment structure will not impact them. DMH will provide information to the MCPs about our contracted network, if it is helpful to them, but as mentioned the referrals will come from DMH through HSH rather than from our contracted network.

DPH-SAPC participates in countywide CalAIM and Community Supports coordination efforts, and regular meetings with the two largest MCPs in LA County where information on the behavioral health housing provider network is shared. DPH-SAPC began implementation of Transitional Rent as an MCP-contracted provider on 01/2026, and completed the following planning activities:

- Mapping existing SAPC-contracted housing providers
- Sharing updated network lists and service descriptions with MCPs
- Developing a referral pathway and shared point-of-contact protocols for future implementation of Transitional Rent

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

6. What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

DMH response:

It is our understanding that the MCPs must ensure there is a funding commitment at the end of the TR subsidy for any clients approved for TR, which if followed should ensure there is no gap. For all clients accessing DMH BHSA HI-funded housing resources that are referred for TR, DMH will make a commitment to continue to fund their housing if TR is denied or once it ends since they will already be in our housing for which we have contracts.

Rather than contracting directly with the MCPs to be a CalAIM Community Supports TR and HD provider, DMH will partner with the Los Angeles County Department of HSH through an MOU. This partnership leverages HSH's existing contracts with the MCPs as well as their workflows, policies and procedures, claiming system and payment and reimbursement procedures. DMH been working with HSH and the MCPs to develop workflows, forms and a common understanding of the DHCS guidance on TR. For all clients that are accessing DMH housing resources for which we are required to leverage TR or HDs, DMH will confirm through the Aves system whether the client has Medi-Cal and their MCP. A Housing Support Plan and authorization form will be developed and submitted to HSH, who will submit the authorization to the MCP. DMH is in discussions with the MCP plans and DHCS to determine the workflow for referrals to determine BHSA eligibility for individuals referred

for TR that do not originate from DMH.

DPH-SAPC response: To avoid service gaps once Transitional Rent or other MCP housing supports are exhausted, DPH-SAPC utilizes other non-Medi-Cal funding sources and/or coordinates with the county's broader housing system, including LAHSA, the Department of Mental Health, DHS Housing for Health, and other housing-focused departments to minimize any service gaps.

Flexible Housing Subsidy Pools

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

For related policy information, refer to [7.C.8 Flexible Housing Subsidy Pools](#).

1. **Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)? Yes**
 - a. **Is the county behavioral health system participating in or planning to participate in the Flex Pool? Yes**
 - b. **What role does the county behavioral health system have or plan to have in the Flex Pool? Funder and Housing Supportive Services Provider**
 - c. **What organization is serving as the Operator? Brilliant Corners for DMH.**
 - d. **Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool? Yes**
 - i. 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
 - Participation Assistance Funds
2. **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**

DMH will work with Brilliant Corners and BHSA HI providers to ensure they understand what TR and HD are, inform them of our workflows to ensure there is no duplication of effort.

DPH-SAPC plays a key collaborative and funding support role in Los Angeles County's Flex Pool infrastructure. While not a Lead Entity or Operator, DPH-SAPC contributes to the broader system by:

- Referring BHSA-eligible individuals to housing units or subsidy opportunities managed by the Flex Pool.
- Participating in multi-agency coordination meetings, including the BHSA workgroup, CalAIM implementation teams, and countywide housing planning efforts to ensure alignment between BHSA Housing Interventions and the

operational scope of the Flex Pool.
DPH-SAPC will continue to engage in policy and systems-level planning to improve how BHSA Housing Interventions integrate with the existing Flex Pool, including future considerations for joint funding applications, data sharing agreements, and system-wide outcomes tracking.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information.

- 1. Does the county's plan include the development of innovative programs or pilots? No**

DRAFT

Workforce Strategy

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and
2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.
3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.
 - a. **Does the county intend to adopt this recommended approach for BHSA- funded providers that also participate in the county’s Medi-Cal Behavioral Health Delivery System? Yes**
 - b. **Does the county intend to adopt this recommended approach for BHSA- funded providers that do not participate in the county’s Medi-Cal Behavioral Health Delivery System? Yes**

Build Workforce to Address Statewide Behavioral Health Goals

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

Assess Workforce Gaps

1. **What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)? 20%**
2. **Upload any data source(s) used to determine vacancy rate: N/A**
3. **For county behavioral health (including county-operated providers), the following five positions have the greatest vacancy rates for LACDMH:**
 - Licensed Clinical Social Worker
 - Licensed Psychologist
 - Psychiatric Technician (PT)
 - Psychiatrist
 - Other qualified provider
4. **Please describe any other key workforce gaps in the county**

The Department annually assesses workforce training needs which will become more challenging to provide with the loss of dedicated WET funds. Historically DMH has delivered and procured training to ensure the workforce has access to clinical best practices.

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

There will be an increased focus on the training, delivery and sustainability of EBP practice use. LA County DMH will build upon its 20+ year history of delivering EBPs to our client population, utilizing Implementation Science principles and learning.

DMH will work with the COEs to ensure the workforce delivering the BH-CONNECT/BHSA EBPs are supported in their work. E-CHWs will be supported by the Chief of Peer Services. DMH will build upon identifying workforce training needs through the annual training plan process.

There will also be an increased need for DPH-SAPC specific roles including more MAT prescribers, more co-occurring treatment capacity, and additional SUD counselors. To address these needs, DPH-SAPC offers incentives including value-based payments to support MAT prescriber capacity expansion, value-based payments to support LPHA capacity expansion, and Tuition Incentive Programs along with value-based payments to support SUD counselor capacity expansion.

Address Workforce Gaps

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

1. **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program? Yes**

a. **Please explain any actions or activities the county is engaging in to leverage the program:** DPH-SAPC and DMH have been promoting the Behavioral Health Scholarship Program to DMC-ODS certified agencies for eligible practitioners. DMH sent out information on the BH Scholarship program to graduate programs that we have academic affiliation agreements with. DPH-SAPC sent out two notifications to the DMC-ODS provider network describing the program including eligibility and links on how to access HCAI's website, how to register for the webinar, and how to apply. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

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

a. **Please explain any actions or activities the county is engaging in to leverage the program:** DPH-SAPC and DMH have been promoting the Behavioral Health Student Loan Payment Program to DMC-ODS certified agencies and DMH provider network to support practitioners eligible for loan repayment. DMH sent out a link to HCAI's website to its workforce and to our contracted providers. DPH-SAPC sent out

notifications to the DMC-ODS provider network describing the program including eligibility and links on how to access HCAI's website, how to register for the webinar, and how to apply. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

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

a. Please explain any actions or activities the county is engaging in to leverage the program: DPH-SAPC and DMH will promote the Behavioral Health Recruitment and Retention Program to DMC-ODS certified agencies to support behavioral health recruitment and retention. DMH has sent relevant information out to its workforce. DPH-SAPC intends to send out notifications to the DMC-ODS provider network on this program when the application and deadlines are available. DPH-SAPC shared this opportunity in advance to contracted training providers that supports SUD counselors in locating internship placements in advance of the release of application. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

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

a. Please explain any actions or activities the county is engaging in to leverage the program: DPH-SAPC and DMH will promote the Behavioral Health Community-Based Provider Training Program to DMC-ODS certified agencies to support community-based provider training. DPH-SAPC sends notifications to its provider network describing the program including eligibility and links on how to access HCAI's website, how to register for the webinar, and how to apply. The HCAI website with BH Connect workforce programs has also been shared to SAPC's Provider Advisory Committee on Workforce.

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

6. Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training

As the data indicate, LACDMH faces a substantial vacancy rate for psychologists in particular. Competition for psychologists is extremely high, with attractive alternatives such as private practice delivered via telehealth, university-based research positions, and recruitment from the VA.

LACDMH has maintained a recruitment presence at the American Psychological Association and California Psychological Association conventions for the last three years and is posting job opportunities through Division 18 (Public Service) of the American Psychological Association. In addition, LACDMH has conducted lunch-and-learn talks at local psychology schools. Recently, LACDMH has dedicated a psychologist leader to reach out to each applicant who applies for the Clinical Psychology I and II positions, to engage them on opportunities within LACDMH.

As described in the above section specific to addiction medications, DPH-SAPC is

applying incentive funding from its value-based reimbursement approach under CalAIM Behavioral Health Payment Reform to DMC-ODS certified agencies to support their recruitment of medical clinicians and licensed behavioral health clinicians to ensure addiction medications, psychiatric support, and integrated co-occurring clinical capability is available from the staff serving clients in DMC-ODS settings.

DRAFT

Budget And Prudent Reserve

1. **Please upload the completed [budget](#) template:** See Attachment #D
2. **Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template:**
 - a. Behavioral Health Services and Supports (BHSS): N/A
 - b. Full Service Partnership (FSP): N/A
 - c. Housing Interventions: N/A
3. **Enter date of last prudent reserve assessment:** 01/08/2026
4. **Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan**
 - a. BHSS: N/A
 - b. FSP: N/A
 - c. Housing Interventions: N/A

DRAFT

Plan Approval and Compliance

Behavioral Health Director Certification

1. I hereby certify that **Los Angeles County** has complied with all statutes, regulations, and guidelines in preparing and submitting this Three-Year Integrated Plan (IP) for Behavioral Health Services and Outcomes, including [all fiscal accountability and stakeholder participation requirements](#). I further certify that (please select all below) [multi-select list]
 - a. The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
 - b. I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
 - c. The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
 - d. Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
 - e. BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
 - f. The IP was submitted to the local behavioral health board
2. **Does the county wish to disclose any implementation challenges or concerns with these requirements?** No

Contact information

1. **County Name:** Los Angeles
2. **Certification for:** Three-Year Integrated Plan-Draft
3. **County Behavioral Health Agency Director Name:** Lisa Wong, Psy.D.
4. **County Behavioral Health Agency Director Phone Number:** (213) 947-6770
5. **County Behavioral Health Agency Director Email:** lwong@dmh.lacounty.gov
6. **SUD Director:** Gary Tsai, MD
7. **Title:** Director, Substance Abuse Prevention and Control (SAPC) Bureau
8. **Phone:** (626) 299-4595
9. **Email:** gtsai@ph.lacounty.gov

County Behavioral Health Agency Director Signature and SUD Director: See Attachment #E

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

1. I hereby certify that (please select all below)
 - a. The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
 - b. Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
 - c. BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
2. **Does the county wish to disclose any implementation challenges or concerns with these requirements?** No

Contact information

3. **County Name:** Los Angeles
4. **Certification for:** Three-Year Integrated Plan-DRAFT
5. **County Chief Administration Officer Name:** Joseph M. Nicchitta
6. **County Chief Administration Officer Phone Number:** (213) 974-1101
7. **County Chief Administration Officer Email:** jnicchitta@ceo.lacounty.gov

Signature: See Attachment #F

From: County of Los Angeles <lacounty@subscriptions.lacounty.gov>
Sent: Monday, March 23, 2026 4:08 PM
To: Robin Ramirez
Subject: Resources to assist with understanding the BHSa Integrated Plan (IP) and Save the Date for the IP Public Hearing - April 9, 2026 10a-1:30p

Dear Stakeholders,

DMH is providing three concise documents (attached to this message) to support your understanding of the BHSa Integrated Plan (IP). Use them as a supplement to your review of the IP. The attached materials are intended to clarify concepts, summarize key sections, and illustrate budget-related considerations. We hope that these documents are helpful in your review.

DMH continues to seek as many stakeholder perspectives as possible in review and input of our BHSa IP. We hope that you are able to participate in the Public Hearing for the IP, which will take place at the **Behavioral Health Commission Meeting** scheduled for Thursday, April 9, 2026 from 10:00 a.m. – 1:30 p.m.

The hearing will be held in person at 510 S. Vermont Ave, Los Angeles, CA 90020, on the Terrace Level. You can also participate in the meeting virtually at the MS Teams link below. Please note that the meeting starts at 10a (an hour earlier than the regular Commission meeting).

[Join the meeting now](#)

Meeting ID: 249 974 756 863 67

Passcode: rY2gx389

Dial in by phone

[+1 323-776-6996.618916441#](tel:+13237766996618916441) United States, Los Angeles

[Find a local number](#)

Phone conference ID: 618 916 441#

Requests for interpretation services in languages other than Spanish and Korean must be submitted in writing to communitystakeholder@dmh.lacounty.gov no later than Monday, March 30, 2026.

Sincerely,

Dr. Darlesh K. Horn, Division Chief

Behavioral Health Services Act (BHSA) Administration Division

Community & Stakeholder Engagement

County of Los Angeles – Department of Mental Health

[BHSA Budget Explanation-Spanish.pdf](#)

[BHSA Budget Explanation-Korean.pdf](#)

[BHSA Budget Explanation-English.pdf](#)

[Executive Summary-English.pdf](#)

[ExecutiveSummary-Korean.pdf](#)

[Executive Summary-Spanish.pdf](#)

[Integrated Plan Overview-English.pdf](#)

[Integrated Plan Overview-Korean.pdf](#)

[Integrated Plan Overview-Spanish.pdf](#)

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This service is provided to you at no charge by the [County of Los Angeles](#).

This email was sent using GovDelivery Communications Cloud to ramirez@dmh.lacounty.gov on behalf of: County of Los Angeles, California - 500 W. Temple St. - Los Angeles 90012



From: [County of Los Angeles](#)
To: [Robin Ramirez](#)
Subject: FRIENDLY REMINDER: Public Hearing for the Draft BHSa Integrated Plan on Thursday, April 9, 2026, 10 AM to 1:30 PM
Date: Wednesday, April 1, 2026 5:13:17 PM

A continuación encontrarás este mensaje en español.

아래에서 이 메시지는 한국어로 되어 있습니다.

DEAR BHSa STAKEHOLDERS,

The Los Angeles County Behavioral Health Commission will have a public hearing on the *Draft BHSa Integrated Plan* on Thursday, April 9, 2026, from 10:00 to 1:30 PM at the DMH Headquarters, 9th Floor Terrace, located at 510 S. Vermont, Los Angeles, CA 90020.

The meeting is open to the public. The public can attend in person or watch the live stream using this link: [Join event](#). If you want to offer public comments remotely, please use these lines:

English: 844-291-6362 | Access Code: 4972277 Spanish: 323-776-6996 |
Conference ID: 444855048 Korean: 323-776-6996 | Conference ID: 228880303

Materials for the session can be accessed by clicking this link: [BHSa Announcements - Department of Mental Health \(lacounty.gov\)](#).

Please hold the following dates for BHSa CPT meetings in 2026: May 12, June 9, July 14, August 11, September 8, October 13, November 10, and December 8. All meetings are on the second Tuesday of each month from 9:30-12:30.

If you have any questions about this message, please contact us at communitystakeholder@dmh.lacounty.gov

Sincerely

DARLESH HORN, *Division Chief*

BHSa Administration Division

Community & Stakeholder Engagement

County of Los Angeles - Department of Mental Health

RECORDATORIO AMISTOSO: Audiencia pública para el Borrador del Plan Integrado de la BHSa el jueves 9 de abril de 2026, de 10:00 a 13:30

ESTIMADOS GRUPOS DE INTERÉS DE LA BHSA,

La Comisión de Salud Conductual del Condado de Los Ángeles celebrará una audiencia pública sobre el *Borrador del Plan Integrado de la BHSA* el jueves 9 de abril de 2026, de 10:00 AM a 1:30 PM en la sede del DMH, 9ª planta Terrace, situada en 510 S. Vermont, Los Ángeles, CA 90020.

La reunión es abierta al público. El público puede asistir en persona o ver la retransmisión en directo usando este enlace: [Únete al evento](#). Si desea ofrecer comentarios públicos de forma remota, por favor utilice estas líneas:

Inglés: 844-291-6362 | Código de acceso: 4972277

Español: 323-776-6996 | ID de conferencia: 444855048

Coreano: 323-776-6996 | ID de conferencia: 228880303

Pueden obtener los materiales para la sesión haciendo clic en este enlace: [Anuncios BHSA - Departamento de Salud Mental \(lacounty.gov\)](#).

Por favor, fije las siguientes fechas para las reuniones CPT de la BHSA en 2026: 12 de mayo, 9 de junio, 14 de julio, 11 de agosto, 8 de septiembre, 13 de octubre, 10 de noviembre y 8 de diciembre. Todas las reuniones se celebran el segundo martes de cada mes de 9:30 a 12:30.

Si tiene alguna pregunta sobre este mensaje, por favor contáctenos en communitystakeholder@dmh.lacounty.gov

Atentamente

DARLESH HORN, *Jefe de División*

División de Administración de la BHSA

Participación de la comunidad y los grupos de interés

Condado de Los Ángeles - Departamento de Salud Mental

친절한 알림: 2026년 4월 9일 목요일 오전 10시부터 오후 1시 30분까지 BHSA 통합 계획 초안에 대한 공개 청문회가 열립니다

친애하는 BHSA 이해관계자 여러분,

로스앤젤레스 카운티 행동 건강 위원회는 2026년 4월 9일 목요일 오후 10시부터 1시 30 분까지 DMH 본부 9층 테라스(주소: 510 S. Vermont, LA 90020)에서 BHSA 통합 계획 초안에 대한 공개 청문회를 개최할 예정입니다.

이 회의는 일반인에게 공개되어 있습니다. 일반인은 직접 참석하거나 이 링크를 통해

라이브 스트림을 시청할 수 있습니다: [행사 참여](#). 원격으로 공개 의견을 제공하고 싶으시다면, 다음 문구를 사용해 주세요:

영어: 844-291-6362 | 접근 코드: 4972277

스페인어: 323-776-6996 | 컨퍼런스 ID: 444855048

한국어: 323-776-6996 | 컨퍼런스 ID: 228880303

세션 자료는 다음 링크를 클릭하여 접근할 수 있습니다: [BHSA 공지사항 - 정신건강부\(lacounty.gov\)](#).

2026년 BHSA CPT 회의 날짜는 5월 12일, 6월 9일, 7월 14일, 8월 11일, 9월 8일, 10월 13일, 11월 10일, 12월 8일로 기다려 주시기 바랍니다. 모든 모임은 매월 둘째 주 화요일 오전 9시 30분부터 12시 30분까지 열립니다.

이 메시지에 대해 궁금한 점이 있으시면 언제든지 communitystakeholder@dmh.lacounty.gov 로 연락해 주세요

진심을 담아

달레시 혼 박사, 부서장

BHSA 행정부

지역사회 및 이해관계자 참여

로스앤젤레스 카운티 - 정신건강부

- [PPT - IP Summary Curated KOR FINAL.pdf](#)
- [PPT - IP Summary Curated ENG FINAL.pdf](#)
- [PPT - IP Summary Curated SPN FINAL.pdf](#)

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BEHAVIORAL HEALTH COMMISSION MONTHLY MEETING



WHY JOIN?

This meeting is a wonderful chance to get involved in the annual Behavioral Services Act (BHSa) public hearing. We encourage you to share your thoughts, concerns, and ideas about the new BHSa. Your input is valuable and will help the Commission create a letter of recommendations to the Departments of Mental Health (DMH), Public Health Substance Abuse Prevention and Control Bureau, and the Los Angeles Board of Supervisors. We look forward to hearing from you and working together to make a positive impact!

NEXT MEETING



THURSDAY
APRIL 09, 2026



10:00 AM



510 S. Vermont Ave.
Los Angeles, CA 90020

CALL-IN INFORMATION



English line: 844-291-6362
participant code 4972277



Spanish line: 323-776-6996
conference ID 444855048



Korean line: 323-776-6996
conference ID 228880303



Watch live stream at

dmh.lacounty.gov/bhc-teams-link

CONTACT US

213-947-6487 or 213-948-2463
mhcommission@dmh.lacounty.gov

Robin Ramirez

From: County of Los Angeles <lacounty@subscriptions.lacounty.gov>
Sent: Wednesday, February 11, 2026 4:50 PM
To: Robin Ramirez
Subject: Notice of Public Comment Period for Los Angeles County Draft BHSA Integrated Plan

Mensaje en español después del mensaje en inglés

한국어 메시지는 끝에 있습니다

The Los Angeles County Department of Mental Health (DMH) and Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC) invite members of the public to submit comments on Los Angeles County's *draft* Behavioral Health Services Act Integrated Plan (BHSA IP) for fiscal years 2026-2027 through 2028-2029. Two versions are posted:

- The [state](#) version follows the California Department of Health Care Services' formatting and word limits per section.
- The [local](#) version is more reader-friendly, containing all the content in the state version, while providing more details per section.

The public can provide comments on one or both versions using this Public Comment Form covering four key sections of the BHSA IP:

1. Statewide Population Behavioral Health Goals
2. Behavioral Health Services Act/Fund Programs
3. Workforce Strategy
4. Budget and Prudent Reserve

The [Public Comment Form](#) also offers a 'General Comments' box at the end where the public can add comments on any other BHSA IP sections not covered in the four sections listed above.

After you complete the Public Comment Form, please indicate which stakeholder group(s) you represent. Add your contact information at the end if you want to receive a notification of DMH's and DPH-SAPC's response(s) to your comment(s).

The Public Comment period begins on **Wednesday, February 11, 2026**, and ends at **11:59 PM on Friday, March 13, 2026**.

If you have any questions about this notice, email us at communitystakeholder@dmh.lacounty.gov

DR. DARLESH HORN

Division Chief, MHS Division of Administration
 Los Angeles County Department of Mental Health

ASUNTO: Aviso de periodo de comentarios públicos para el borrador del Plan Integrado de la BHSa del condado de Los Ángeles

ESTIMADOS INTERESADOS DE LA COMUNIDAD BHSa,

El Departamento de Salud Mental del Condado de Los Ángeles (DMH) y el Departamento de Salud Pública – Prevención y Control del Abuso de Sustancias (DPH-SAPC) invitan al público a presentar comentarios sobre el borrador del Plan Integrado de la Ley de Servicios de Salud Conductual del Condado de Los Ángeles (BHSa IP, por sus siglas en inglés) para los años fiscales 2026-2027 a 2028-2029. Se publican dos versiones:

- La versión [estatal](#) sigue el formato y los límites de palabras por sección del Departamento de Servicios de Salud de California.
- La versión [local](#) es más fácil de leer, contiene todo el contenido de la versión estatal, y además ofrece más detalles por sección.

El público puede proporcionar comentarios sobre una o ambas versiones utilizando este Formulario de Comentarios Públicos que cubre cuatro secciones clave del BHSa IP:

1. Objetivos estatales de salud conductual de la población
2. Ley de Servicios de Salud Conductual/Programas del fondo
3. Estrategia de Fuerza Laboral
4. Presupuesto y Reserva Prudente

El [Formulario de Comentarios Públicos](#) también ofrece una casilla de 'Comentarios Generales' al final donde el público puede añadir comentarios sobre cualquier otra sección del BHSa que no esté cubierta en las cuatro secciones mencionadas anteriormente.

Después de completar el Formulario, por favor indique qué grupo(s) de interesados representa. Añade tu información de contacto al final si quieres recibir una notificación de la respuesta de DMH y DPH-SAPC a tu(s) comentario(s).

El período de comentarios públicos comienza el **miércoles 11 de febrero de 2026** y finaliza a las 11:59 p.m. del **viernes 13 de marzo de 2026**.

Si tiene alguna pregunta sobre este aviso, envíenos un correo electrónico a communitystakeholder@dmh.lacounty.gov

DR. DARLESH HORN

Jefe de División, División de Administración de MHSa
Departamento de Salud Mental del Condado de Los Ángeles

제목: 로스앤젤레스 카운티 BHSa 통합 계획(초안)에 대한 공개 의견 수렴 기간 안내

BHSa 커뮤니티 이해관계자 여러분께,

로스앤젤레스 카운티 정신건강국(DMH)과 공중보건국-약물남용 예방 및 관리국(DPH-SAPC)은 시민 여러분께서 로스앤젤레스 카운티의 행동건강서비스법(BHSA) 통합 계획 초안(2026-2027 회계연도부터 2028-2029 회계연도까지)에 대한 의견을 제출해 주시기를 요청 드립니다. 현재 두 가지 버전이 게시되어 있습니다:

- **주정부** 버전(State Version)은 캘리포니아 보건의료 서비스국의 형식 및 섹션별 단어 제한을 준수합니다.
- **지역** 버전은 주정부 버전의 모든 내용을 포함하면서도, 각 섹션에 대해 더 자세한 설명을 제공하여 읽기 쉽게 구성되어 있습니다.

시민 여러분께서는 본 의견 제출 양식을 통해 한 가지 또는 두 가지 버전 모두에 대해 의견을 제시하실 수 있습니다. 이 양식은 BHSA 통합 계획의 네 가지 핵심 섹션을 다룹니다:

1. 주 전역 인구 행동건강 목표
2. 행동건강서비스법/기금 프로그램
3. 인력 전략
4. 예산 및 적정 예비금

또한, 의견 제출 양식 하단에는 '일반 의견'란이 마련되어 있어, 위에서 언급한 네 가지 섹션 외에 다른 BHSA 통합 계획 섹션에 대한 의견도 자유롭게 추가하실 수 있습니다.

공개 의견 제출 양식을 작성하신 후, 본인이 대표하는 이해관계자 그룹(들)을 표시해 주시기 바랍니다. 또한 의견에 대한 DMH 및 DPH-SAPC의 답변 통지를 받고자 하시는 경우, 마지막에 연락처 정보를 입력해 주세요.

대중 의견 수렴 기간은 2026년 2월 11일 수요일에 시작하여 2026년 3월 13일 금요일 오후 11시 59분에 종료됩니다.

본 공지와 관련하여 질문이 있으시면 아래 이메일로 문의해 주시기 바랍니다:
communitystakeholder@dmh.lacounty.gov

DARLESH HORN 박사, *과장*

MHSA 행정과(MHSA Division of Administration)

로스앤젤레스 카운티 정신건강국(Los Angeles County Department of Mental Health)

- [Los Angeles County BHSA Integrated Plan Local Version 2-11-2026 \(Spanish\) with attachments.pdf](#)
- [Los Angeles County BHSA Integrated Plan Local Version 2-11-2026 \(Korean\) with attachments.pdf](#)
- [STATE-Los Angeles County BHSA Integrated Plan 2026-29.pdf](#)
- [Los Angeles County BHSA Integrated Plan Local Version 2-11-2026 \(English\) with attachments.pdf](#)

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The screenshot shows a web browser displaying the Los Angeles County Department of Mental Health website. The page title is "BHSA/MHSA ANNOUNCEMENTS". The main content area features a table of upcoming meetings for 2026:

Meeting Date	Time
January 29	9:30am - 12:30pm
February 19	9:30am - 12:30pm
May 12	9:30am - 12:30pm
June 9	9:30am - 12:30pm
July 14	9:30am - 12:30pm
October 13	9:30am - 12:30pm

Below the table, there is a "NOTICE OF PUBLIC COMMENT PERIOD (FEB. 11, 2026 – MAR. 13, 2026) FOR LOS ANGELES COUNTY DRAFT BHSA INTEGRATED PLAN". The notice includes text in Spanish, English, and Korean. A footer note states: "The [draft](#) version follows the California Department of Health Care Services' formatting and word limits per section."



Quality Assessment and Performance Improvement (QAPI) Work Plan January 2026- June 2027

March 2026

Presented By:

Los Angeles County Department of Mental Health
Quality, Outcomes, and Training Division, Quality Improvement Unit

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control, Quality Improvement Branch



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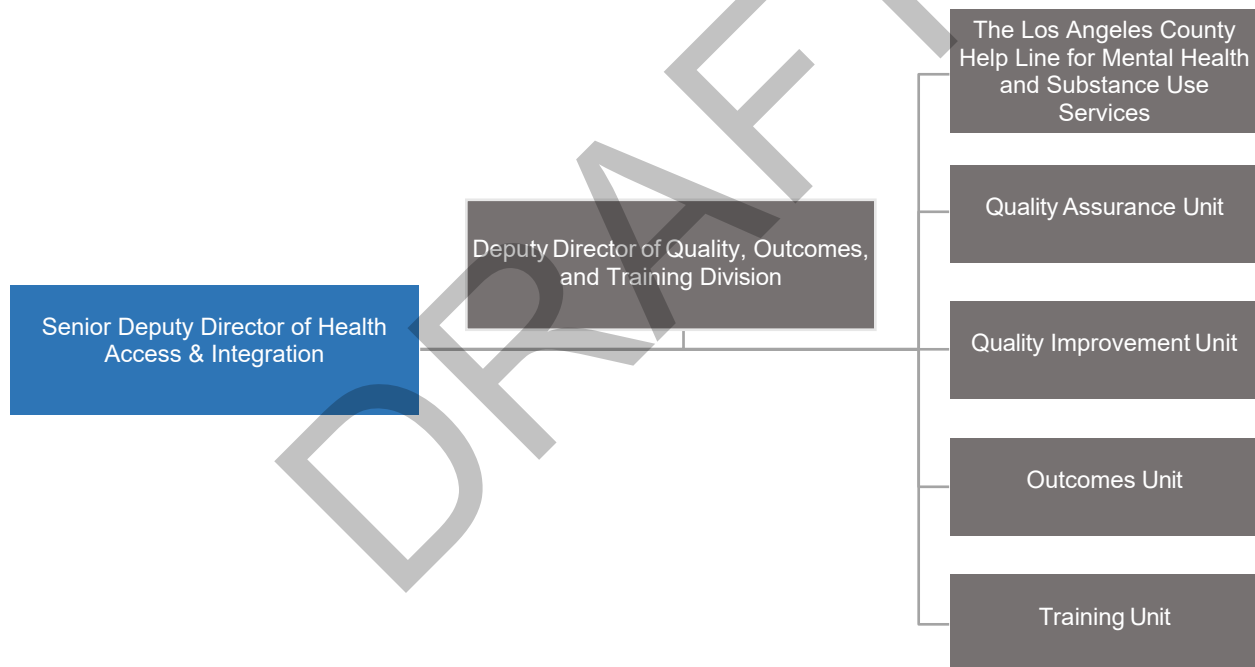
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QUALITY IMPROVEMENT (QI) PROGRAM PURPOSE AND SCOPE

Department of Mental Health

Under the leadership of the Senior Deputy Director of Health Access and Integration, the Deputy Director of Quality, Outcomes, and Training Division (QOTD) oversees the units responsible for assessing accessibility of services, assessing member satisfaction, establishing qualitative measures to assess performance, identifying areas in need of improvement, and overall monitoring of the quality of the Department's services in conformance with Federal, State, and local QI requirements. These units include Quality Assurance (QA), Quality Improvement, Outcomes, Training, and The Los Angeles County Help Line. QOTD's organizational structure facilitates a downward and upward communication loop between Specialty Mental Health Services (SMHS) providers countywide, various units within the department responsible for monitoring performance throughout the operations of the Los Angeles County Department of Mental Health (LACDMH), and LACDMH executive management.



The Los Angeles County Help Line for Mental Health and Substance Use Services

LACDMH and Los Angeles County Department of Public Health Substance Abuse Prevention and Control collaboratively operate a centralized 24/7 Help Line that simplifies the road to recovery for those seeking care for mental health and/or substance use disorders. This serves as the entry point for mental health and substance use services in Los Angeles County. While the majority of calls are for information and referral, the line also facilitates the deployment of Field Intervention Teams (FITs), has a dedicated emotional support line and serves as the gatekeeper for acute inpatient psychiatric beds, interpreter services, and emergency member transportation to psychiatric emergency rooms. For more information visit: <https://dmh.lacounty.gov/blog/2024/08/welcome-l-a-county-help-line-for-mental-health-and-substance-use-services/>

Quality Assurance Unit

The QA Unit ensures the adherence of the County Mental Health Plan's (MHP) directly operated (DO) and contracted providers to federal, state, and local laws, regulations, and requirements associated with the provision, documentation, and claiming of Medi-Cal SMHS. The QA Unit develops policies and guidelines; monitors adherence to governmental mandates; provides training and technical support; certifies the MHP's SMHS providers; supports the clinical functions of the Department's electronic health record (EHR) system; oversees the integrity, retention, and release of the Department's clinical records; acts as a liaison between the MHP and the State Department of Health Care Services (DHCS) including during the DHCS Triennial System/Chart review and Short/Doyle Medi-Cal Hospital audits; and advocates for the MHP's position on SMHS-related issues with DHCS, the County Behavioral Health Director's Association (CBHDA), and other entities. The QA Unit ensures adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and External Quality Review Organization (EQRO) audits. In addition, the QA Unit is responsible for the credentialing of clinical staff across the Specialty Mental Health System and manages the electronic data platforms that track and report on timely access and Network Adequacy. The QA unit is responsible for the Department's Annual Test Calls to identify areas in need of improvement with regards to cultural and linguistic responsiveness, customer service, referrals to SMHS, tracking/monitoring, and appropriate documentation of call information. They are also responsible for Medi-Cal certification of sites, LPS designation and State Fair Hearings. For more information visit: <https://dmh.lacounty.gov/qa/>

Quality Improvement Unit

The QI Unit in conformance with Federal, State, and local QI requirements oversees technical reporting related to the annual Quality Assurance and Performance Improvement (QAPI) Work Plan and Evaluation Report, coordinates efforts to assess member/family satisfaction by implementing the annual Consumer Perception Surveys (CPS) and evaluates and reports member/family satisfaction data. The QI unit is responsible for the state-mandated Performance Improvement Projects (PIPs) and their validation during External Quality Review (EQR) audits. PIP committee members are chosen by the QI Unit who have relevant experience and/or expertise with the PIP topic to ensure that improvement plans and strategies are well informed and that improvement efforts are coordinated. The QI Unit is also responsible for coordinating the Quality Improvement Committee (QIC) meetings, evaluating the population of consumers served and the services delivered to identify areas in need of improvement, and coordinate with other departmental units to develop quality improvement plans and strategies to address these areas. Additionally, the QI unit provides technical assistance, consultation, and training around the professional use of QI practices and strategies to promote a culture of Continuous Quality Improvement (CQI) and to support QI efforts where they occur. For more information visit: <https://dmh.lacounty.gov/qid/>.

Outcomes Unit

The Outcomes Unit is responsible for selecting, developing, disseminating, training, collecting, and reporting outcome measures associated with the Department's mental health programs, including mandated ones. The Outcomes Unit provides operational elements and business rules to the Chief Information Office Bureau (CIOB) to develop or customize data collection and reporting systems. The Outcomes Unit conducts data queries and creates dashboards to display outcomes and other data elements. For more information visit: <https://dmh.lacounty.gov/outcomes/>

Training Unit

The Training Unit is responsible for workforce development, ensuring a diverse workforce reflective of the members served, education, and providing training and technical assistance for the clinical and non-clinical public mental health workforce. For more information visit: <https://dmh.lacounty.gov/providers/clinical-tools/training-workforce-development/>

Additional Units and Divisions Outside of QOTD

Chief Information Office Bureau (CIOB)

A large portion of the Department's CQI work requires ongoing coordination with CIOB, namely:

- Compiling countywide information on members served and member populations; and
- Developing an internal application to collect and report annual member satisfaction data electronically in multiple languages.

CIOB's Clinical Informatics team holds essential roles in both PIPs, from aggregating data to offering technical assistance to the clinical PIP lead tasked with analyzing the data. They are also tasked with calculating LACDMH's Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Cultural Competency Unit (CCU)

CCU is part of the Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division and is overseen by the Ethnic Services Manager (ESM). The ESM provides technical assistance to the Cultural Competency Committee (CCC) and is a standing member of the Departmental QIC. This structure facilitates communication and collaboration for attaining the goals outlined in the QAPI Work Plan and Cultural Competency (CC) Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additional information on the CCU and its functions, the CCC, the Institute for Cultural Linguistic Inclusion and Responsiveness (ICLIR), a tri-Countywide Cultural and Linguistic Competency workgroup, and our most recent CC Plan is available via the CCU website at <https://dmh.lacounty.gov/ccu/>.

Patient's Rights' Office (PRO)

The Patient's Rights Office is responsible for investigating and responding to grievances and complaints about inpatient and outpatient mental health services. They review the data from member grievances, appeals, and expedited appeals. PRO also manages all Change of Provider (COP) requests and Senate Bill (SB) 929 data. For more information visit: <https://dmh.lacounty.gov/our-services/patients-rights/>

Office of the Chief Medical Officer

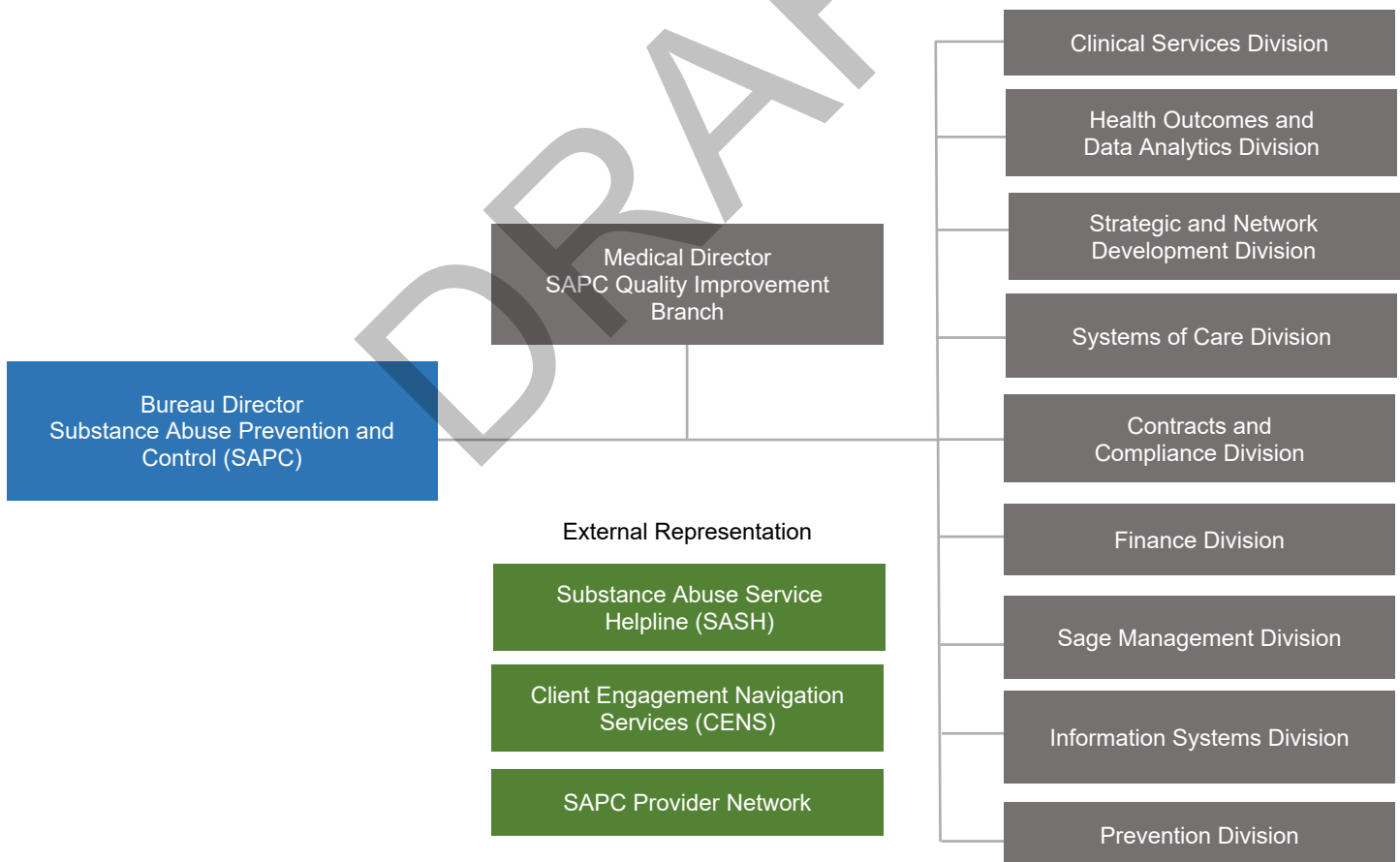
The Office of the Chief Medical Officer is responsible for ensuring practice guidelines/ parameters are based on valid and reliable clinical evidence or a consensus of health care professionals in the field, consider the needs of our members, are adopted in consultation with network providers, and are reviewed every two years and updated as appropriate. They also monitor the safety and effectiveness of medication practices and oversee the Clinical Risk Management Unit.

Department of Public Health – Substance Abuse Prevention and Control

Los Angeles County specialty substance use disorder (SUD) system is managed by the Substance Abuse Prevention and Control Bureau within the Department of Public Health (SAPC). SAPC’s provider network offers specialty SUD treatment services for youth and adults who are enrolled or eligible for Los Angeles County Medi-Cal, and/or participating in another eligible County funded program. This program continues to focus on quality improvement within the treatment network focused on:

1. Integrating physical and mental health service needs with SUD services;
2. Training quality standards to improve health outcomes;
3. Providing the full continuum of SUD services to meet the needs of patients;
4. Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan; and
5. Solidifying SUD’s status as a chronic health condition rather than as an acute condition.

These enhancements enable SUD patients to receive quality services that match their individualized needs and preferences and overall improve health and social outcomes.



Quality Improvement Branch

SAPC's Quality Improvement (QI) Branch is focused on the identification and development of quality improvement projects, specifically including the identified Performance Improvement Projects (PIPs). The QI Division conducts provider-interfacing quality improvement around access to priority clinical services (such as MAT), conducts biannual documentation review of key quality metrics, and holds member focus groups to learn more about the patient perspective on treatment delivered by the SAPC provider network. The branch centralizes the process of clinical grievances and appeals (G&A) and spends a portion of their time processing authorizations for treatment in collaboration with SAPC's overall Clinical Services Division. The QI Branch interfaces with other key SAPC units to carry forward SAPC's quality improvement initiatives (such as harm reduction and access to care).

Quality Improvement Accountability, Governing Body, and Committee Structure

SAPC's Quality and Risk Management Committee provides a forum for discussion and the provision of direction to the other units with SAPC and is the framework for organizational quality improvement and oversight responsibilities. Most committees are internal and attended by SAPC branch representatives and relevant parties. There are two committees that include external stakeholders, including member referral services and representatives from the SAPC provider network. Each committee is independently governed but report to the Quality Improvement & Risk Management Committee as lead committee.

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QUALITY IMPROVEMENT COMMITTEE AND STRUCTURE

Behavioral Health Administrative Integration QI Steering Committee

Statement of Purpose

The purpose of the Behavioral Health Administrative Integration (BHA) QI Steering Committee is for both LACDMH and LACDPH SAPC to coordinate efforts to improve service delivery for members in need of SMHS and SUD services in Los Angeles with special attention to members with co-occurring needs.

Committee Membership

LACDMH:

- QOTD Deputy
- QA Unit
- QI Unit
- Clinical Informatics

LACDPH SAPC:

- QI Branch
- Health Outcomes and Data Analytics Division

Department of Mental Health

Quality Improvement Committee (QIC) - Statement of Purpose

The purpose of the QIC is to monitor the appropriateness and quality of services provided to LACDMH members with the aim of improving the processes of providing care and better meeting the needs of our members. The QIC is a central part of LACDMH's Quality Assessment and Performance Improvement Program and shall recommend policy decisions; review and evaluate the results of QI activities, including PIPs; institute needed QI actions; ensure follow-up of QI processes; and document QAPI Committee meeting minutes regarding decisions and actions taken. LACDMH holds two types of QIC meetings, the Countywide QIC meeting and the Regional QIC meeting. In addition, there are various other meetings focused on quality improvement activities and efforts. Those meetings will be described in further detail below. The Countywide and Regional QIC meetings provide opportunities to:

- Review and evaluate data;
- Identify QI issues and projects;
- Foster an environment where stakeholders can discuss QI activities;
- Identify possible best practices; and
- Ensure performance standards align with the Department's mission and strategic plan.

Countywide QIC

The Countywide (CW) QIC meetings occur on a monthly basis and are led by the QI Unit, which is responsible for reviewing service delivery and quality of care data, evaluating the results of QI activities including QAPI WP goals, recommending system improvements, and recommending policy changes. Effective by the end of the first quarter of 2026, the CW QIC will be subsumed by the QAPI Leadership Committee (renamed from Access to Care Leadership Committee as described below).

Committee Membership

LACDMH Quality Improvement Committee membership reflects the diverse perspectives of members from administrative programs and providers from throughout the county. SAPC began attending DMH CW QIC meetings last year in efforts to integrate QI endeavors and ensure quality improvement activities around members with co-occurring substance use disorders are addressed. The Cultural Competency Unit supervisor is a standing member of the QIC which supports integration of cultural competency goals and quality improvement efforts such as reducing disparities and improving the quality and availability of culturally responsive and linguistically appropriate services throughout the county. The QIC membership includes representatives from:

- Child Welfare
- Clinical Informatics
- Clinical Risk Management
- Compliance, Privacy, and Audit Services
- Contracts, Management and Monitoring Division
- Cultural Competency Unit
- Emergency Outreach and Triage Division
- Forensic Services
- Managed Care Operations
- Managed Plan Operations
- The Los Angeles County Help Line for Mental Health and Substance Use Services
- Mental Health Services Act (MHSA)
- Outcomes
- Outpatient Care Services
- Patients' Rights Office
- Peer Services
- Pharmacy/ Psychiatry
- Quality Assurance Unit
- Quality Improvement Unit
- Training

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental CW QIC Chair. The QIC Chair is responsible for chairing and facilitating meetings and ensuring members receive timely and relevant information.

Regional QIC Meetings

Regional QIC meetings are convened on a quarterly basis. The Northern Regional QIC encompasses Service Areas 1-4 and Southern Regional QIC has members from Service Areas 5-8. QI Unit staff co-lead the meetings along with a SA Lead. LACDMH providers are required to identify a QI staff from their agency or clinic to attend and participate in Regional QIC meetings. Many of the staff in attendance are also practitioners within their clinics. The Regional QIC includes sharing data on quality improvement efforts such as the PIPs, CPS, and WP goals and solicitation of QIC members' input/feedback to improve our system of care. Each committee meeting provides a structured forum for identifying QI opportunities to address challenges and barriers unique to their respective SA or region. Providers are asked to share quality improvement projects in their SAs or clinics. This approach fosters integrative discussions of departmental QA goals in concert with QI practices. Meeting minutes and recordings (when applicable) are posted online at <https://dmh.lacounty.gov/qid/> for public review.

Additional QAPI Committees and Meetings

Access to Care Leadership Committee (will be renamed QAPI Leadership Committee)

The Access to Care Leadership committee is comprised of core managers from various sectors of LACDMH's system of care. The committee meets bimonthly, with system-wide data review occurring at least monthly. The committee members work collaboratively to address the external (systemic) factors contributing to timely access challenges seen in the data or identified by providers with the goal of improving overall access to care. The Access to Care Leadership committee's developers ensured QI Unit presence early to bring QI strategies to the workgroup. This inclusion was part of an effort to promote a culture of quality improvement within the Department. This collaboration has evolved, beginning with developing a Performance Improvement Project focused on timeliness. The Access to Care Leadership committee has also become a platform for reviewing service and outcome data and gaining leadership recommendations and direction on performance improvement. The group meets twice monthly to address access and timeliness performance across Specialty Mental Health. In March 2026 it will be broadened to include metrics the MHP is responsible for reporting on and achieving.

Access to Care Action Committee (will be renamed QAPI Action Committee)

This committee meets every other month and is inclusive of network providers who work jointly with DMH leadership to identify strategies to improve performance on timely access to care and follow up access to care, network adequacy and system capacity. This committee provides valuable input into developing adult and child levels of outpatient care and has been a partner in mapping CANS data to child levels of care and LOCUS implementation for adult clients.

Stakeholder Engagement

The QICs encourage stakeholder involvement in all QI activities. Service Area Leadership Teams (SALTs), MHSA Community Planning Team (CPT), and Underserved Cultural Community (UsCC) meetings are all avenues for feedback from stakeholders around quality improvement needs.

All Programs of Excellence (APEX)

APEX is a forum that brings together supervisors, managers, and multiple divisions to address areas of the Outpatient Care Services (OCS) Performance Dashboard indicators where improvement is needed. OCS organizes APEX meetings by SA and program. Types of services provided, number of new assessments completed, active and inactive clients, hospitalization and 30 day rehospitalization rates, access to care rates, service location (telehealth, telephone, or in person), overdue UMDAPs, denied claims reasons, mental health diagnoses and co-occurring SUD diagnoses, percent of clients with SUD diagnosis who receive Medication Assisted Treatment (MAT) services, Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS), Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Needs Evaluation Tool (NET), and housing status data are provided at each session by month. The APEX process is grounded in the following values: maintain a problem-solving approach, support positive change, remove systemic challenges, enhance coordination and communication between divisions, share evolving procedures, scale best practices, and provide excellent customer service (internal/external).

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Department of Public Health – Substance Abuse Prevention and Control

Quality Improvement and Risk Management Committee

In accordance with the Special Terms and Conditions (STCs) of California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, and the Quality Improvement (QI) and Utilization Management (UM) sections of the Provider Manual, the purpose of the QI & RM Committee is to provide a forum by which various relevant divisions across the organization can regularly meet to discuss issues related to network performance, outcomes, capacity, training, and concerns, all with the overarching goal of optimizing outcomes and minimizing the possibility of adverse outcomes or loss. In doing so, the QI & RM Committee will request, review, and lead the administrative and clinical quality improvement activities within SAPC, including problem identification and the formulation of quality improvement plans. The QI & RM Committee meets every other month with representatives from all SAPC areas responsible for managing the SAPC SUD treatment provider network.

COMMITTEE RESPONSIBILITIES

Core responsibilities of the **QI & RM Committee** include the following:

- Establish and maintain an integrated strategy to ensure patient safety and satisfaction, quality of care, and organizational efficiencies.
- Review and evaluate the results of quality improvement activities.
- Develop, implement, and manage the two PIPs that counties are required to implement on an annual basis, with one PIP focusing on a clinical issue and another PIP focusing on a non-clinical issue.
- Track, monitor, prepare, and ensure compliance with EQRO and other State requirements by reviewing subcommittee reports on a biannual basis.
- Review targeted clinical records associated with flagged complaint/grievance and appeals filed by patients, their representatives, and/or providers.
- Recommend policy decisions related to quality improvement and risk management.

COMMITTEE STRUCTURE

The QI & RM Committee shall be led by a chair (SAPC Director) and co-chair (SAPC Deputy Director) (or their designees as needed). Members of the Committee shall be decided by consensus of the Committee, under the leadership of the chair and co-chair.

Members of the QI & RM Committee shall represent the following SAPC Branches and Divisions:

- Executive Office (SAPC Director and Deputy Director of Treatment)
- Clinical Service Division
- Health Outcome and Data Analytics Division
- Strategic and Network Development Division
- Systems of Care Division
- Contracts and Compliance Division
- Finance Division
- SAGE Management (Electronic Health Record) Division
- Information Systems Division
- Prevention Division

External representation will include:

- The Los Angeles County Help Line for Mental Health and Substance Use Services
- Client Engagement Navigation Services (CENS)
- SAPC Provider Network

PROCEDURES

The procedures for the QI & RM Committee are indicated below:

Meetings. The Committee chairs, in consultation with other members of the Committee, will determine the frequency and length of the Committee meetings. However, the Committee shall meet at minimum every other month. The committee will meet regularly on dates that are announced in advance and the agenda will be developed by the chairs of the Committee in consultation with the Committee's membership. Attendees of meetings will be at the discretion of the Committee in consultation with involved stakeholders.

Reports. Meeting minutes serve to document the Committee's activities and may include information regarding outcomes, recommendations, actions taken, and follow up items from previous meetings. Minutes shall be circulated during and/or prior to the scheduled Committee meetings.

Performance Improvement Projects. The Committee will develop, implement, and manage the two PIPs that counties are required to implement on an annual basis, with one PIP focusing on clinical issues and another PIP focusing on non-clinical issues.

External Quality Review Organization (EQRO) Responsibilities. The Committee will track, monitor, prepare, and ensure compliance with EQRO and other State requirements.

Oversight. The Committee will review and monitor the following provider submissions:

- **Reportable Incidents:** Reportable incidents are patient safety events that result in death, permanent harm, severe temporary harm, and/or intervention required to sustain life. Reportable Incidents must be reported to the SAPC Contracts and Compliance Division, which will then ensure that the appropriate entities within SAPC are included and raise this to the QI & RM Committee. Additionally, the Risk Management Committee at the provider agency level is also required to investigate Reportable Incidents.
- **Adverse Events:** Adverse Events are incidents that have a direct or indirect impact on the community, patients, staff, and/or the entire provider agency. Adverse Events must be addressed by the Risk Management Committee at the provider agency level and are submitted to SAPC at provider discretion. If the SAPC Contracts and Compliance Division deems an Adverse Event as requiring input from the QI & RM Committee, it can be submitted to the Committee for review.
- **Complaint/Grievance:** A complaint or grievance from patients or providers are an expressed dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment. These occurrences will be addressed as a component of the SAPC Contracts and Compliance Division and typically will not be reviewed by the QI & RM Committee unless a specific complaint/grievance is identified and rises to the level of requiring involvement of the QI & RM Committee.

Record Keeping. Documentation and reviews of Reportable Incidents, and applicable Adverse Events and Complaints/Grievances will be maintained, and such records may be kept in hard copy, electronically, or both. In either case, sufficient safeguards will be established (e.g., locked cabinets for hard copy files, password protection and encryption for electronic files, access for authorized staff only) to maintain confidentiality.

Committee Findings. Notable findings of the QI & RM Committee will be incorporated into provider educational programs, the re-credentialing and contracting process, and annual review evaluations. All quality improvement and risk management activities and resulting actions will be documented to demonstrate the Committee's impact on improving service delivery across the SAPC network. Additionally, quality improvement and risk management activities will recognize the importance of constructive outcomes as well as correcting instances of deficient practice. In instances of deficient practice, written Corrective Action Plans (CAPs) will be submitted to and reviewed by the Committee. CAPs will fall into one of three categories: systems actions, educational actions, or individual follow-up and will detail what was done, who was responsible, and the timeframe for completion and follow-up.

Confidentiality. All activities and findings of the QI and RM Committee are confidential under CA Evidence Code Section 1157.6 related to Peer Review Activities and Government Code 825 related to Personnel Records and as a Patient Safety Work Product under the Patient Safety Organization (PSO): An entity established pursuant to the Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 42 U.S. C. 299b-21—b26 (Reference 2) and the regulations that interpret it, 42 CFR Parts 2 and 3. All SAPC contracted providers are required to comply with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations (Confidentiality of Alcohol and Drug Abuse Patient Records).

QUALITY IMPROVEMENT WORKPLAN

Department of Mental Health

DMH reviews metrics for the following areas for improvement opportunities at least quarterly:

- Timeliness of first initial contact to face-to-face appointment or synchronous video or audio-only interaction, consistent with BHIN 23-018 or any subsequent Departmental guidance.
- Frequency of follow-up appointments.
- Access to after-hours care.
- Responsiveness of the member access line.
- Strategies to reduce avoidable hospitalizations.
- Coordination of physical, mental health, and SUD services at the provider level.
- Assessment of the members' experiences.
- Telephone access line and services in the prevalent non-English languages.
- Member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical records reviews as required by 9 C.C.R. section 1810.440(a)(5) and 42 C.F.R. section 438.416(a) and our Contract.
- Evidence that QI activities, including PIPs, have contributed to meaningful improvement in clinical care and member service.

DMH's QAPI Work Plan for 2026- 27 is organized into six significant domains: Service Delivery Capacity, Member Satisfaction, Clinical Care, Continuity of Care, Accessibility of Services and Performance Improvement Projects. Each domain is designed to address service needs and service quality. Work Plan goals are identified based on feedback from Triennial audits, External Quality Reviews, member satisfaction data, quality metrics, and other reports indicating areas needing improvement. For 2026-27, Accessibility of Services is the focus of the Non-clinical Performance Improvement Project.

The QAPI Work Plan is a living document. The Department's QIC will review QAPI Work Plan goals and related progress bi-annually to ensure coverage of all components of the QAPI Work Plan. Moreover, the QI Unit and QICs will be tasked with reviewing and assessing the results of QAPI Work Plan activities, recommending policy decisions, and monitoring the progress of the clinical and non-clinical PIPs. Stakeholders can use the following QAPI Work Plan as a resource for informed decision-making and planning. A detailed version of DMH's Work Plan for 2026- 27 is available in Appendix A.

DMH's Work Plan 2026- 27

NO.	DOMAIN	GOAL
1A.	Service Delivery Capacity	Improve language accessibility for our members and community stakeholders.
1B.	Service Delivery Capacity	80% or more of ACCESS mental health-related calls are answered within 1 minute or less, measured monthly.
2A.	Member Satisfaction	Increase Social Connectedness and Perception of Functioning domain scores for Adult Consumer Perception Surveys (CPS) to 80%.
2B.	Member Satisfaction	Increase the number of Consumer Perception Surveys received by 5% from prior year.
2C.	Member Satisfaction	Monitor grievances, appeals and requests for a Change of Provider (COP) to identify areas of improvement in our system.
3A.	Clinical Care	100% of adult outpatient Specialty Mental Health providers will utilize the LOCUS as directed in QA Bulletin 24-09R as a clinical decision aid to identify service frequency and intensity.
3B.	Clinical Care	Meet or exceed Minimum Performance Levels set by DHCS for key Healthcare Effectiveness Data and Information Set (HEDIS) measures.
3C.	Clinical Care	Evaluation of the Quality Assurance and Performance Improvement (QAPI) Program.
4A.	Continuity of Care	Reduce Adult 7 and 30-day rehospitalization rates.
4B.	Continuity of Care	Develop Population Health Management (PHM) Strategy and Evaluate PHM Plan.
5.	Accessibility of Services	Ensure 100% of Psychiatry Data is Captured to Calculate Timeliness of Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+.
6A.	Performance Improvement Projects	Clinical PIP for 2026- 27 will continue to aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) 30-day measurement rate.
6B.	Performance Improvement Projects & Accessibility of Services	Non-clinical PIP for 2026- 27 will continue to aim to improve access from first contact from any referrals source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.

Department of Public Health – Substance Abuse Prevention and Control

SAPC's Quality Improvement & Risk Management (QI/RM) Committee meets every other month, and our QI Branch meets every other week to identify opportunities to improve quality of services, manage compliance and risk management, review complaints/grievances and appeals, ensure cross-division collaboration and information exchange, and support provider-level quality improvement.

We adopted this QI Work Plan for 2026- 27 and updated QI Program Goals and Objectives to describe our plan to assess SAPC-network performance against best practice guidelines and implement interventions which ensure that SUD services follow generally accepted standards of clinical practice. We elaborated three specific focus areas to this end: our EQRO Process Improvement Plans, our use of the QI/RM committee and QI Branch to compile and review positive and negative variances in quality, and to ensure collaboration and information exchange related to QI within SAPC in accordance with priority metrics.

We specifically align the QI Program metrics to accord with the DMC-ODS STCs and DHCS BHIN 24-001, as described above, and will review and update these metrics with subsequent revisions to the DMC-ODS terms and conditions. We prioritized measures in the areas of access to care, timeliness of care, quality of provider documentation, quality of provider care, compliance with utilization management timeframe and standards, and care outcomes.

SAPC's QI Branch collaborates with the Contracts and Compliance Division to process grievances and appeals in accordance with SAPC policies and procedures related to processing grievances, including those described within current version of the SAPC provider manual, and with all applicable state policies.

SAPC's QI Branch reviews each grievance and appeal from provider agencies resulting from adverse determinations related to patient financial eligibility and documentation to identify reasons for overturning these adverse determinations to identify instances where there was retrospective resolution to financial eligibility, including instances where the transition of the patient's county of residence, where there were adjudication errors, where there were technology errors, and in instances where retrospective changes in state policy resulted in changes in patient eligibility for services.

SAPC's QI Branch further conducts a twice-a-year review of a sample of patient charts from the contracted provider network to review the following additional documentation metrics for CY 2026- 27:

- Percent of charts reviewed with late documentation (in accordance with BHIN 23-068)
- Percent of charts reviewed where there was missing documentation of LPHA involvement and review of Problem List or Treatment Plan.
- Percent of admissions where service hours did not align with the provided level of care.
- Percent of admissions where there was lack of alignment between ASAM Assessment and the documented plan of care.

- Percent of admissions where we identified the providers did not refer to appropriate mental health, physical health, housing, legal (DCFS, Court, Probation, etc.)
- Percent of admissions where there was not adequate discharge planning.
- Percent of care coordination notes that did not describe appropriate care coordination services.
- Percent of admissions where appropriate release of information documentation was missing.
- Percent of admissions for withdrawal management where medications for withdrawal during the treatment episode were documented
- Percent of admissions where provider agencies document that they prevented or discouraged the patient from accessing medications for addiction treatment.
- Percent of admissions for patients with opioid use disorder where medications for opioid use disorder were discussed and offered.
- Percent of admissions for patients with opioid use disorder where medications for opioid use disorder were provided, directly or through referral.
- Percent of admissions for patients with alcohol use disorder where medications for alcohol use disorder were discussed and offered.
- Percent of admissions for patients with alcohol use disorder where medications for alcohol use disorder were provided, directly or through referral.
- Percent of admissions for patients with tobacco use disorder where medications for alcohol use disorder were discussed and offered.
- Percent of admissions for patients with tobacco use disorder where medications for alcohol use disorder were provided, directly or through referral.

These documentation metrics are reviewed and revised twice annually as additional documentation trends and issues are identified by QI Branch staff.

The QI Branch's identification of documentation and quality findings are stratified by agency and are used during SAPC's monitoring of our provider agencies to inform the application of appropriate corrective action plans. SAPC's recoupment is limited to instances where there was evidence of fraud waste and/or abuse. For instances of documentation noncompliance, SAPC issues corrective action plans that include the provision of technical assistance and intensification of trainings and updating training content, and other appropriate non-recoupment administrative sanctions.

The SAPC QI Branch, along with the existing SAPC Quality Improvement & Risk Management (QI/RM) Committee, will continue to update and revise the SAPC QI Work Plan throughout 2026- 27.



LOS ANGELES COUNTY
**DEPARTMENT OF
MENTAL HEALTH**
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Appendix A – Department of Mental Health (DMH) Quality Assessment and Performance Improvement (QAPI) Detailed Work Plan

Reporting Period January 2026- June 2027

Presented By:

Los Angeles County Department of Mental Health
Quality, Outcomes, and Training Division, Quality Improvement Unit

Monitoring Service Delivery Capacity

Service Equity

Goal 1a. Improve language accessibility for our members and community stakeholders.	
Objective(s)	<ol style="list-style-type: none"> 1. Update Departmental Language Accessibility Plan (DLAP). 2. Administer Needs Assessment survey around language accessibility needs amid staff and stakeholders. 3. Continue to assess member satisfaction with American Sign Language (ASL) interpreter services. 4. Increase language access for languages other than English members and family members including ASL.
Population	Los Angeles County members and families who receive outpatient SMHS from LACDMH DO and LE/Contracted providers who speak languages other than English and those who are deaf or hard of hearing
Performance Indicator(s)	<ol style="list-style-type: none"> 1. Report on Provider Language Capacity 2. Report on findings from language Needs Assessment 3. Rate of member satisfaction with ASL interpreter services 4. Number of language accessibility resources from prior year to present
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division/ Cultural Competency Unit (CCU), Program Manager III and Health Program Analyst III

Goal 1b. 80% or more of ACCESS mental health-related calls are answered within 1 minute or less, measured monthly.

Objective(s)	<ol style="list-style-type: none"> 1. Staffing & scheduling (work closely with Workforce Management- WFM): <ol style="list-style-type: none"> a. Hire all vacant positions b. Analyze call volume data to create optimized schedules 2. Call workflow Improvements: <ol style="list-style-type: none"> a. Upload quick reference guides for common questions into Agent Assist 3. Accountability & Monitoring: <ol style="list-style-type: none"> a. Analyze call metrics daily to determine barriers b. Monitor the Verizon Contact Center (VCC) during peak hours to adjust skill sets c. Evaluate staff performance by utilizing weekly team performance reports
Population	All Los Angeles County Residents
Performance Indicator(s)	<ol style="list-style-type: none"> 1. Percent of vacancies filled 2. Percent of calls answered within 60 seconds 3. Average speed of calls answered
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	ACCESS Program Manager IIs

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Monitoring Member Satisfaction

Goal 2a. Increase Social Connectedness and Perception of Functioning domain scores for Adult Consumer Perceptions Surveys (CPS) to 80%.	
Objective(s)	1. QAPI Leadership Committee and Regional QICs will identify key drivers and interventions to increase satisfaction for Adults in Social Connectedness and Perception of Functioning domains.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Satisfaction rates in Social Connectedness and Perception of Functioning domains for Adults
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Supervising Psychologist

Goal 2b. Increase the number of total Consumer Perception Surveys received by 5% from prior year.	
Objective(s)	<ol style="list-style-type: none"> 1. Increase provider participation by identifying providers who did not submit any surveys during the 2025 CPS survey period and offer technical support. 2. Work with DO and LE providers as well as TAY Division and Peer Services to identify interventions to increase participation.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	<ol style="list-style-type: none"> 1. Rate of provider participation 2. Rate of participation in survey by age groups
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Supervising Psychologist

Member Grievances, Appeals, and Change of Provider Requests

Goal 2c. Monitor grievances, appeals and requests for a Change of Provider (COP) to identify areas of improvement in our system.	
Objective(s)	<ol style="list-style-type: none">1. Work with CIOB on updating applications for Grievances and Appeals to meet State requirements.2. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies.3. Utilize data captured in Grievances and Appeals and COP application to identify practitioners or facilities who continuously receive grievances and appeals and COP requests.4. Continue to develop PowerBI Dashboard to visualize trends in data.
Population	Los Angeles County residents engaging in DMH services [outpatient, inpatient, Fee for Service (FFS)]
Performance Indicator(s)	<ol style="list-style-type: none">1. Total number of complaints and resolutions by type in Year 2026-272. COP requests by type in Year 2026-27
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Patient's Rights Office, Mental Health Program Manager I

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Monitoring Clinical Care

Level of Care

Goal 3a.	100% of adult outpatient Specialty Mental Health providers will utilize the LOCUS as directed in QA Bulletin 24-09R as a clinical decision aid to identify service frequency and intensity.
Objective(s)	<ol style="list-style-type: none">1. Review LOCUS aggregate data monthly with DMH leaders and managers as well as Legal Entity providers for trends, recommended policy and practice changes and systemic capacity issues.2. At that program and practitioner level, utilize LOCUS information to inform case conceptualizations, treatment planning and decisions on when and how to transition clients to higher or lower levels of care.
Population	Adult members, ages 21 and above, receiving outpatient services
Performance Indicator(s)	<ol style="list-style-type: none">1. Number of staff who have completed LOCUS training by provider site2. Percent of clients at each level of care3. Percent of clients scoring level 0 or 1 (non-Specialty Mental Health levels of care)4. Percent of clients with repeated administration of the LOCUS with levels of care that are higher, lower or with no change
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Outcomes Unit Program Manager II and III

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal 3b. Meet or exceed Minimum Performance Levels set by DHCS for key Healthcare Effectiveness Data and Information Set (HEDIS) measures.	
Objective(s)	<ol style="list-style-type: none"> 1. Track and assess progress on the following County MHP Priority Performance Measures: <ul style="list-style-type: none"> • Follow Up After Emergency Department Visit for Mental Illness (FUM) • Follow Up After Hospitalization for Mental Illness (FUH) • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) • Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) • Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD) • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 2. Continue to develop Power BI Dashboards that track HEDIS measures. 3. Continue to collaborate with Managed Care Plans (MCPs) on data exchange for timely interventions. 4. Utilize QAPI Leadership and Action Committees for any measures below Minimum Performance Level (MPL) to plan for interventions designed to improve performance.
Population	All Medi-Cal members that meet criteria to be included in any of the above HEDIS measures
Performance Indicator(s)	<ol style="list-style-type: none"> 1. Meet MPLs set by DHCS 2. Reports produced to demonstrate HEDIS Measure performance
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	CIOB Clinical Informatics Supervising Data Scientist and Clinical Pharmacy, Pharmacy Services Chief III

Goal 3c.	Evaluation of the Quality Assessment and Performance Improvement (QAPI) Program.
Objective(s)	1. Develop and deliver a survey to evaluate satisfaction with the QI team's processes and support to providers and other departmental units that are part of the QAPI.
Population	DMH staff and DO/LE Providers
Performance Indicator(s)	1. Rate of satisfaction of Countywide QIC/ QAPI Leadership Committee, Regional QIC, QI website, and support from QI Unit
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Program Manager I

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Monitoring Continuity of Care

Goal 4a. Reduce Adult 7 and 30-day rehospitalization rates.	
Objective(s)	<ol style="list-style-type: none">1. Build a 7 and 30-day rehospitalization PowerBI dashboard that analyzes areas of improvement by service areas and individual providing hospitals.2. Implement Hospital Liaisons in each SA to coordinate care from inpatient to outpatient services.3. Implement Care Coordination Teams and trainings in each SA on best practices for coordinating care.4. Work with Managed Care Plans and Clinical Informatics team to identify high utilizers to target interventions towards.5. Complete chart reviews on high utilizer clients to identify themes that may be impacting higher rates of rehospitalization.
Population	LACDMH members who are high utilizers of hospitals defined as those who are rehospitalized at 7 and 30 days after last discharge.
Performance Indicator(s)	<ol style="list-style-type: none">1. Rate of 7-and 30-day rehospitalizations2. Rate of 7- and 30-day follow-up with mental health services after discharge from hospital
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Outpatient Care Services, Supervising Psychologist

Goal 4b. Develop Population Health Management (PHM) Strategy and Evaluate PHM Plan.

Objective	<ol style="list-style-type: none"> 1) Create a comprehensive documented PHM strategy that focuses on and has goals for the following: <ol style="list-style-type: none"> a) Keeping members healthy. b) Managing members with emerging risk. c) Patient safety or outcomes across settings. d) Managing multiple chronic illnesses. 2) Conduct a comprehensive analysis of the impact of the PHM strategy that includes: <ol style="list-style-type: none"> a) Quantitative results for relevant clinical, cost/utilization and experience measures. b) Comparison of results with a benchmark or goal. c) Interpretation of results.
Population	LACDMH members
Performance Indicator(s)	<ol style="list-style-type: none"> 1. PHM Strategy disseminated to members 2. PHM Strategy Analysis Report
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QOTD Deputy Director

Accessibility of Services

Goal 5. Ensure 100% of Psychiatry Data is Captured to Calculate Timeliness of Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+.	
Objective	1. Increase number of Legal Entity CSI Assessment submissions for psychiatry data by identifying providers who have submitted no records in a 3-month period and requiring an action plan by the provider to begin submitting.
Population	Members aged 0-20 and 21+ requesting psychiatry appointments.
Performance Indicator(s)	1. Rate of Timely Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Assurance Program Manager I

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Monitoring Performance Improvement Projects

Goal 6a. Clinical PIP for 2026- 27 will aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) 30-day measurement rate.	
Objective	<ol style="list-style-type: none"> 1. Complete barrier analysis utilizing QI tools (fishbone diagram etc.). 2. Continue to work collaboratively with PIP committee members to identify and implement at least one intervention. 3. Work with Clinical Informatics team to ensure accurate numerator and denominator.
Population	Members age 6+ who visit an emergency department for mental illness or intentional self-harm.
Performance Indicator(s)	1. Rate of 7-and 30-day FUM
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Improvement Psychologist II, Clinical Informatics, Supervising Psychologist

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Monitoring Performance Improvement Projects & Accessibility Of Services

Goal 6b.	Non- clinical PIP for 2026- 27 will aim to improve access from first contact from any referral source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.
Objective	<ol style="list-style-type: none"> 1. Complete barrier analysis utilizing QI tools (fishbone diagram etc.). 2. Continue to work collaboratively with PIP committee members to identify and implement at least one intervention. 3. Work with Clinical Informatics team to ensure accurate numerator and denominator.
Population	Children accessing SMHS through DO and LE/Contracted providers
Performance Indicator(s)	1. Number of Child non-psychiatry routine appointments offered within 10 business days
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Assurance, Program Manager II and Quality Improvement Clinical Psychologist II

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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	<input checked="" type="checkbox"/>	\$ 6,166,000.00	\$ 6,166,000.00	\$ 6,166,000.00	\$ 25,661,000.00	\$ 25,661,000.00	\$ 25,661,000.00	42,000	158,000
Early Intervention Services	<input checked="" type="checkbox"/>	\$ -	\$ -	\$ -	\$ 304,000.00	\$ 314,000.00	\$ 330,000.00	0	142
Outpatient Services	<input checked="" type="checkbox"/>	\$ 132,713,000.00	\$ 136,866,000.00	\$ 143,986,000.00	\$ 8,523,000.00	\$ 8,790,000.00	\$ 9,247,000.00	22,118	2,134
Intensive Outpatient Services	<input checked="" type="checkbox"/>	\$ 76,208,000.00	\$ 78,593,000.00	\$ 82,682,000.00	\$ 3,837,000.00	\$ 3,957,000.00	\$ 4,163,000.00	9,613	498
Crisis and Field-Based Services	<input checked="" type="checkbox"/>	\$ 21,758,000.00	\$ 22,439,000.00	\$ 23,606,000.00	\$ 335,000.00	\$ 346,000.00	\$ 364,000.00	4,373	90
Residential Treatment Services	<input checked="" type="checkbox"/>	\$ 291,989,000.00	\$ 301,124,000.00	\$ 316,790,000.00	\$ 5,941,000.00	\$ 6,127,000.00	\$ 6,446,000.00	16,598	485
Inpatient Services	<input checked="" type="checkbox"/>	\$ 30,353,000.00	\$ 31,303,000.00	\$ 32,931,000.00	\$ 199,000.00	\$ 205,000.00	\$ 216,000.00	2,991	36
Mental Health (MH) Services									
Primary Prevention Services	<input checked="" type="checkbox"/>	\$ 30,275,000.00	\$ 31,425,000.00	\$ 32,431,000.00	\$ -	\$ -	\$ -	4,325	0
Early Intervention Services	<input checked="" type="checkbox"/>	\$ 95,975,000.00	\$ 99,622,000.00	\$ 102,810,000.00	\$ 931,822,000.00	\$ 967,231,000.00	\$ 997,747,000.00	51,300	81,404
Outpatient and Intensive Outpatient Services	<input checked="" type="checkbox"/>	\$ 1,087,932,000.00	\$ 1,129,037,000.00	\$ 1,164,106,000.00	\$ 121,387,000.00	\$ 124,018,000.00	\$ 127,987,000.00	116,992	17,421
Crisis Services	<input checked="" type="checkbox"/>	\$ 259,178,000.00	\$ 269,028,000.00	\$ 277,637,000.00	\$ 20,470,000.00	\$ 21,248,000.00	\$ 21,928,000.00	17,190	11,096
Residential Treatment Services	<input checked="" type="checkbox"/>	\$ 44,393,000.00	\$ 46,080,000.00	\$ 47,555,000.00	\$ 4,611,000.00	\$ 4,786,000.00	\$ 4,939,000.00	2,298	60
Hospital and Acute Services	<input checked="" type="checkbox"/>	\$ 405,857,000.00	\$ 421,280,000.00	\$ 434,761,000.00	\$ 109,059,000.00	\$ 113,203,000.00	\$ 116,825,000.00	18,373	4,341
Subacute and Long-Term Care Services	<input checked="" type="checkbox"/>	\$ 213,434,000.00	\$ 221,544,000.00	\$ 228,633,000.00	\$ 3,404,000.00	\$ 3,533,000.00	\$ 3,646,000.00	1,721	54
Housing Services (MH + SUD)									
Housing Services	<input checked="" type="checkbox"/>	\$ 336,897,000.00	\$ 346,320,000.00	\$ 309,771,000.00	\$ 10,948,000.00	\$ 15,407,000.00	\$ 16,243,000.00	12,316	355
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		\$ 3,033,128,000.00	\$ 3,140,827,000.00	\$ 3,203,865,000.00	\$ 1,246,501,000.00	\$ 1,294,826,000.00	\$ 1,335,742,000.00	322,208	276,116

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	\$ 81,268,000.00	\$ 56,130,000.00	\$ 42,041,000.00
Workforce Investment Activities	\$ 49,254,000.00	\$ 49,417,000.00	\$ 49,588,000.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	\$ 643,931,000.00	\$ 672,146,000.00	\$ 690,081,000.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	\$ 176,182,000.00	\$ 181,946,000.00	\$ 186,985,000.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	\$ 950,635,000.00	\$ 959,639,000.00	\$ 968,695,000.00

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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	\$ 1,195,995,000.00	\$ 1,257,319,000.00	\$ 1,232,126,000.00
1991 Realignment (Bronzan-McCorquodale Act)	\$ 533,253,000.00	\$ 553,517,000.00	\$ 571,230,000.00
2011 Realignment (Public Safety Realignment)	\$ 838,351,000.00	\$ 874,354,000.00	\$ 906,378,000.00
State General Fund	\$ 137,938,000.00	\$ 143,733,000.00	\$ 149,203,000.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	\$ 1,940,955,000.00	\$ 2,029,935,000.00	\$ 2,182,501,000.00
Projects for Assistance in Transition from Homelessness (PATH)	\$ 1,663,000.00	\$ 1,663,000.00	\$ 1,663,000.00
Community Mental Health Block Grant (MHBG)	\$ 27,817,000.00	\$ 27,817,000.00	\$ 27,817,000.00
Substance Use Block Grant (SUBG)	\$ 60,259,000.00	\$ 60,259,000.00	\$ 60,259,000.00
Commercial Insurance	\$ 1,875,000.00	\$ 1,946,000.00	\$ 2,008,000.00
County General Fund	\$ 72,785,000.00	\$ 72,785,000.00	\$ 72,785,000.00
Opioid Settlement Funds	\$ 15,851,000.00	\$ 15,851,000.00	\$ 15,851,000.00
Other Funding Sources	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
Other federal grants	\$ 6,811,000.00	\$ 6,948,000.00	\$ 7,067,000.00
Other state funding (including DSH funding)	\$ 170,210,000.00	\$ 115,703,000.00	\$ 39,868,000.00
Other county mental health or SUD funding	\$ 226,501,000.00	\$ 233,462,000.00	\$ 239,546,000.00
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)	\$ 5,230,264,000.00	\$ 5,395,292,000.00	\$ 5,508,302,000.00
Total Projected Expenditure Variance	\$ -	\$ -	\$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	\$ 4,279,629,000.00	\$ 4,435,653,000.00	\$ 4,539,607,000.00
Auto-validation: Table 2: Other County Expenditures	\$ 950,635,000.00	\$ 959,639,000.00	\$ 968,695,000.00

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)	\$ 254,661,000.00	\$ 297,105,000.00	\$ 297,105,000.00	\$ 848,871,000.00
Year Two Component Allocation (dollars)	\$ 286,098,000.00	\$ 333,781,000.00	\$ 333,781,000.00	\$ 953,660,000.00
Year Three Component Allocation (dollars)	\$ 303,702,000.00	\$ 354,319,000.00	\$ 354,319,000.00	\$ 1,012,340,000.00

BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	\$ 254,661,000.00	\$ 297,105,000.00	\$ 297,105,000.00	\$ 848,871,000.00
Unspent Mental Health Services Act (MHSA) to BHSA	\$ 37,531,000.00	\$ 286,075,000.00	\$ 1,124,045,000.00	\$ 1,447,651,000.00
Excess Prudent Reserve (PR) to BHSA	\$ -	\$ -	\$ -	\$ -

BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	\$ 286,098,000.00	\$ 333,781,000.00	\$ 333,781,000.00	\$ 953,660,000.00

BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	\$ 303,702,000.00	\$ 354,319,000.00	\$ 354,319,000.00	\$ 1,012,340,000.00

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)		
Base Component (Year One)	Housing Intervention Percentage (Year One)	Housing Intervention Funds (Year One)
Base Percentage and Funding	30%	\$ 254,661,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New Housing Interventions Base Percentage (auto-populated)	30%	\$ 254,661,000.00
Transferred To/From	Full Service Partnership Percentage (Year One)	Full Service Partnership Funds (Year One)
Base Percentage and Funding	35%	\$ 297,105,000.00

Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New FSP Base Percentage (auto-populated)	35%	\$	297,105,000.00
Transferred To/From	Behavioral Health Services and Support Percentage (Year One)	Behavioral Health Services and Support Funding (Year One)	
Base Percentage and Funding	35%	\$	297,105,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New BHSS Base Percentage (auto-populated)	35%	\$	297,105,000.00

Funding Transfers (Year One)

	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)

Base Component (Year Two)	Housing Intervention Percentage (Year Two)	Housing Intervention Funds (Year Two)	
Base Percentage and Funding	30%	\$	286,098,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New Housing Interventions Base Percentage (auto-populated)	30%	\$	286,098,000.00
Transferred To/From	Full Service Partnership Percentage (Year Two)	Full Service Partnership Funds (Year Two)	
Base Percentage and Funding	35%	\$	333,781,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New FSP Base Percentage (auto-populated)	35%	\$	333,781,000.00
Transferred To/From	Behavioral Health Services and Support Percentage (Year Two)	Behavioral Health Services and Support Funding (Year Two)	
Base Percentage and Funding	35%	\$	333,781,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New BHSS Base Percentage (auto-populated)	35%	\$	333,781,000.00

Funding Transfers (Year Two)

	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation
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Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

**Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption
(Ability to change component's overall percentage) (Year Three)**

Base Component	Housing Intervention Percentage (Year Three)	Housing Intervention Funds (Year Three)
Base Percentage and Funding	30%	\$ 303,702,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New Housing Interventions Base Percentage (auto-populated)	30%	\$ 303,702,000.00
Transferred To/From	Full Service Partnership Percentage (Year Three)	Full Service Partnership Funds (Year Three)
Base Percentage and Funding	35%	\$ 354,319,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New FSP Base Percentage (auto-populated)	35%	\$ 354,319,000.00
Transferred To/From	Behavioral Health Services and Support Percentage (Year Three)	Behavioral Health Services and Support Funding (Year Three)
Base Percentage and Funding	35%	\$ 354,319,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New BHSS Base Percentage (auto-populated)	35%	\$ 354,319,000.00

Funding Transfers (Year Three)

	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

MHSA Transfers to BHSA				
MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	\$ 661,228,000.00	\$ -	\$ 130,000,000.00	\$ 531,228,000.00
PEI	\$ 238,772,000.00	\$ -	\$ -	\$ 238,772,000.00
Encumbered INN	\$ 212,249,000.00	\$ 37,531,000.00	\$ 156,075,000.00	\$ 18,645,000.00
Unencumbered INN	\$ -	\$ -	\$ -	\$ -
WET	\$ 155,600,000.00			\$ 155,600,000.00
CFTN	\$ 179,800,000.00			\$ 179,800,000.00
Total (auto-populated)	\$ 1,447,649,000.00	\$ 37,531,000.00	\$ 286,075,000.00	\$ 1,124,045,000.00
Excess Prudent Reserve to BHSA Components				
Transfer from Prudent Reserve to BHSA Component Allocation	Amount			
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	\$ 170,068,541.70			
Local Prudent Reserve Maximum (2)	\$ 172,412,205.15			
Excess Prudent Reserve Funding that must be transferred	\$ (2,343,663.45)			
Housing Intervention (3)	\$ -			
FSP	\$ -			
BHSS (4)	\$ -			
Total Transferred Excess Prudent Reserve (auto-populated)	\$ -			

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Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)			
Total Estimated Housing Intervention Funding Received (BHSA Funds)	\$ 254,661,000.00	\$ 286,098,000.00	\$ 303,702,000.00			
Transfers into Housing Intervention component from Local Prudent Reserve	\$ -	\$ -	\$ -			
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	\$ -	\$ -	\$ -			
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	\$ 254,661,000.00	\$ 286,098,000.00	\$ 303,702,000.00			
Housing Interventions Category						
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	\$ 30,370,000.00	\$ 31,822,000.00	\$ 32,427,000.00	\$ 12,117,000.00	\$ 11,799,000.00	\$ 3,078,000.00
Operating Subsidies	\$ -	\$ -	\$ 2,350,000.00	\$ 9,402,000.00	\$ 9,402,000.00	\$ 7,051,000.00
Bundled Rental and Operating Subsidies	\$ 45,556,000.00	\$ 48,120,000.00	\$ 38,170,000.00	\$ 15,276,000.00	\$ 15,276,000.00	\$ 15,276,000.00
% of Rental and Operating Subsidies Administered through Flex Pools	87%	88%	86%	78%	78%	69%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	\$ 4,633,000.00	\$ 20,051,000.00	\$ 14,051,000.00	\$ 33,472,000.00	\$ 25,670,000.00	\$ 25,670,000.00
Operating Subsidies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Bundled Rental and Operating Subsidies	\$ 38,687,000.00	\$ 70,614,000.00	\$ 119,250,000.00	\$ 68,733,000.00	\$ 47,655,000.00	\$ 1,407,000.00
% of Rental and Operating Subsidies Administered through Flex Pools	74%	86%	92%	100%	100%	100%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	\$ 5,070,000.00	\$ 70,000.00	\$ 70,000.00	\$ 67,000.00	\$ 67,000.00	\$ 67,000.00
Other Housing Supports: Participant Assistant Funds (2)	\$ 5,025,000.00	\$ 5,050,000.00	\$ 4,950,000.00	\$ 996,000.00	\$ 987,000.00	\$ 948,000.00

Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	\$ 24,482,000.00	\$ 32,358,000.00	\$ 26,192,000.00	\$ 7,375,000.00	\$ -	\$ -
Other Housing Supports: Outreach and Engagement (2)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Capital Development Projects	\$ 14,860,000.00	\$ -	\$ -	\$ 25,408,000.00	\$ 15,130,000.00	\$ 1,041,000.00
Housing Flex Pool Expenditures (start-up expenditures)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
BHSA Innovative Housing Intervention Pilots and Projects						
MHSA INN Projects	\$ 12,510,000.00	\$ 12,510,000.00	\$ 12,510,000.00	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 181,193,000.00	\$ 220,595,000.00	\$ 249,970,000.00	\$ 172,846,000.00	\$ 125,986,000.00	\$ 54,538,000.00
Housing Interventions Transfer Information	Year One	Year Two	Year Three			
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	\$ -	\$ -	\$ -			
Housing Interventions Component Administrative Information	Year One	Year Two	Year Three			
Housing Interventions Component Admin Expenses	\$ 25,961,000.00	\$ 24,275,000.00	\$ 21,895,000.00			
Total Housing Interventions Expenditures (auto-populated)	\$ 207,154,000.00	\$ 244,870,000.00	\$ 271,865,000.00			
Housing Interventions Populations to be Served	Year One	Year Two	Year Three			
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	\$ 129,465,000.00	\$ 156,580,000.00	\$ 162,382,000.00			
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	\$ 4,269,000.00	\$ 27,062,000.00	\$ 21,062,000.00			

Housing Interventions Component Funds Validation (auto-populated based on inputs above)	Year One	Year Two	Year Three
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	6.8%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	59.6%	60.0%	55.8%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	298	384	455
Eligible Adults/Older Adults	8296	7590	7600
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year One	Year Two	Year Three
MHSA "Encumbered" INN	\$ 37,531,000.00	\$ 25,021,000.00	\$ 12,511,000.00

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	\$ 297,105,000.00	\$ 333,781,000.00	\$ 354,319,000.00
Transfers into Full Service Partnership component from Local Prudent Reserve	\$ -	\$ -	\$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	\$ 130,000,000.00	\$ -	\$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	\$ 427,105,000.00	\$ 333,781,000.00	\$ 354,319,000.00

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)	\$ 11,654,000.00	\$ 12,097,000.00	\$ 12,484,000.00	\$ 19,892,000.00	\$ 20,648,000.00	\$ 21,309,000.00	\$ 8,223,000.00	\$ 8,535,000.00	\$ 8,808,000.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	\$ 5,265,000.00	\$ 5,465,000.00	\$ 5,640,000.00	\$ 8,718,000.00	\$ 9,049,000.00	\$ 9,339,000.00	\$ 3,604,000.00	\$ 3,741,000.00	\$ 3,861,000.00
FSP Intensive Case Management	\$ 72,876,000.00	\$ 75,645,000.00	\$ 78,066,000.00	\$ 206,187,000.00	\$ 214,022,000.00	\$ 220,871,000.00	\$ 85,236,000.00	\$ 88,475,000.00	\$ 91,306,000.00
High Fidelity Wraparound	\$ 51,503,000.00	\$ 53,460,000.00	\$ 55,171,000.00	\$ 55,762,000.00	\$ 57,881,000.00	\$ 59,733,000.00	\$ 11,498,000.00	\$ 11,935,000.00	\$ 12,317,000.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	\$ 32,059,000.00	\$ 33,277,000.00	\$ 34,342,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Assertive Field-Based Initiation for SUD Treatment Services	\$ 5,807,000.00	\$ 6,028,000.00	\$ 6,221,000.00	\$ 8,278,000.00	\$ 8,593,000.00	\$ 8,868,000.00	\$ 3,422,000.00	\$ 3,552,000.00	\$ 3,666,000.00
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	\$ 51,196,000.00	\$ 51,159,000.00	\$ 53,720,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 230,360,000.00	\$ 237,131,000.00	\$ 245,644,000.00	\$ 298,837,000.00	\$ 310,193,000.00	\$ 320,120,000.00	\$ 111,983,000.00	\$ 116,238,000.00	\$ 119,958,000.00

FSP Transfer Information	Year One	Year Two	Year Three
Transfers out of FSP component into Local Prudent Reserve	\$ 2,343,000.00	\$ -	\$ -
FSP Administrative Information	Year One	Year Two	Year Three
FSP Component Admin Expenses	\$ 55,832,000.00	\$ 57,954,000.00	\$ 59,809,000.00
Total Full Service Partnership Expenditures (auto-populated)	\$ 288,535,000.00	\$ 295,085,000.00	\$ 305,453,000.00
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	3703	3740	3777
Eligible Adults/Older Adults	10443	10547	10652
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year One	Year Two	Year Three
MHSA "Encumbered" INN	\$ 156,075,000.00	\$ 104,879,000.00	\$ 53,720,000.00

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Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	\$ 297,105,000.00	\$ 333,781,000.00	\$ 354,319,000.00
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)	\$ 604,045,000.00	\$ 520,000,000.00	\$ -
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	\$ 901,150,000.00	\$ 853,781,000.00	\$ 354,319,000.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	\$ 43,471,000.00	\$ 45,123,000.00	\$ -	\$ 425,540,000.00	\$ 441,711,000.00	\$ 455,846,000.00	\$ 790,949,000.00	\$ 821,005,000.00	\$ 893,844,000.00
Early Intervention Expenditures	\$ 295,199,000.00	\$ 306,416,000.00	\$ 316,222,000.00	\$ 607,021,000.00	\$ 630,088,000.00	\$ 650,251,000.00	\$ 516,598,000.00	\$ 536,229,000.00	\$ 553,388,000.00
Coordinated Specialty Care for First Episode Psychosis	\$ 6,400,000.00	\$ 6,643,000.00	\$ 6,856,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
All Other EI Expenditures	\$ 288,799,000.00	\$ 299,773,000.00	\$ 309,366,000.00	\$ 607,021,000.00	\$ 630,088,000.00	\$ 650,251,000.00	\$ 516,598,000.00	\$ 536,229,000.00	\$ 553,388,000.00
Outreach and Engagement	\$ 1,625,000.00	\$ 1,687,000.00	\$ 1,741,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Workforce Education and Training (WET)	\$ 35,000,000.00	\$ 35,000,000.00	\$ 35,000,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated BHSA WET funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated MHSA WET funds	\$ 35,000,000.00	\$ 35,000,000.00	\$ 35,000,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Capital Facilities and Technological Needs (CF/N)	\$ 41,000,000.00	\$ 41,000,000.00	\$ 41,000,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated BHSA CF/TN funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated MHSA CF/TN funds	\$ 41,000,000.00	\$ 41,000,000.00	\$ 41,000,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
BHSA Innovative BHSS Pilots and Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MHSA INN Projects	\$ 6,215,000.00	\$ 6,215,000.00	\$ 6,215,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 422,510,000.00	\$ 435,441,000.00	\$ 400,178,000.00	\$ 1,032,561,000.00	\$ 1,071,799,000.00	\$ 1,106,097,000.00	\$ 1,307,547,000.00	\$ 1,357,234,000.00	\$ 1,447,232,000.00

BHSS Prudent Reserve Transfer Information	Year One	Year Two	Year Three
Transfers out of BHSS component into Local Prudent Reserve	\$ -	\$ -	\$ -
BHSS Administrative Information	Year One	Year Two	Year Three
BHSS Component Admin Expenses	\$ 240,561,000.00	\$ 239,702,000.00	\$ 210,771,000.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	\$ 663,071,000.00	\$ 675,143,000.00	\$ 610,949,000.00
Youth-Focused Early Intervention Expenditures	Year One	Year Two	Year Three
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	\$ 238,531,000.00	\$ 247,595,000.00	\$ 255,518,000.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	Year One	Year Two	Year Three
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	54.0%	52.7%	192.0%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	80.8%	80.8%	80.8%
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	83040	83870	84708
Eligible Adults/Older Adults	117925	119104	120295
Projected BHSS Funds transferred to WET or CF/TN	Year One	Year Two	Year Three
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 One	Year Two	Year Three
Estimated MHSa WET Funds	\$ 155,600,000.00	\$ 120,600,000.00	\$ 85,600,000.00
Estimated MHSa CF/TN Funds	\$ 179,800,000.00	\$ 138,800,000.00	\$ 97,800,000.00
MHSa "Encumbered" INN	\$ 18,645,000.00	\$ 12,430,000.00	\$ 6,215,000.00

Table Eight: BHSA Plan Administration

INTEGRATED PLAN ADMINISTRATION AND MONITORING			
	Year One	Year Two	Year Three
Total Projected Improvement and Monitoring Expenditures	\$ 17,589,420.00	\$ 19,738,080.00	\$ 20,944,440.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 13,012,000.00	\$ 13,506,000.00	\$ 13,938,000.00
New and Ongoing Administrative Costs	\$ -	\$ -	\$ -
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	\$ 879,471,000.00	\$ 986,904,000.00	\$ 1,047,222,000.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2.0%	2.0%	2.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	1.5%	1.4%	1.3%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	\$ -	\$ -	\$ -
Planning	\$ -	\$ -	\$ -
Total	\$ -	\$ -	\$ -

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	\$ 170,068,541.70
Local Prudent Reserve Maximum (1)	\$ 172,412,205.15
Excess Prudent Reserve Funds (auto-populated)	\$ (2,343,663.45)
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)	\$ 2,343,000.00
Total Distributions From the Local Prudent Reserve (auto-populated)	\$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).	

Table Ten: BHSA Funding Summary (auto-populated)

	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 254,661,000.00	\$ 297,105,000.00	\$ 297,105,000.00	\$ 848,871,000.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 286,098,000.00	\$ 333,781,000.00	\$ 333,781,000.00	\$ 953,660,000.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 303,702,000.00	\$ 354,319,000.00	\$ 354,319,000.00	\$ 1,012,340,000.00
BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	Full Service Partnerships (Year One)	Behavioral Health Services and Supports (Year One)	Year One Totals
Estimated Year One Component Allocations <i>(BHSA Funding Only)</i>	\$ 254,661,000.00	\$ 297,105,000.00	\$ 297,105,000.00	\$ 848,871,000.00
Transfers From PR Into Component	\$ -	\$ -	\$ -	\$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) <i>(Unspent Carryover MHSA Funds)</i>	\$ -	\$ 130,000,000.00	\$ 604,045,000.00	\$ 734,045,000.00
Estimated Total Available Funding for Year One	\$ 254,661,000.00	\$ 427,105,000.00	\$ 901,150,000.00	\$ 1,582,916,000.00
Transfers from Component Into PR	\$ -	\$ 2,343,000.00	\$ -	\$ 2,343,000.00
Estimated Total Year One Expenditures	\$ 207,154,000.00	\$ 288,535,000.00	\$ 663,071,000.00	\$ 1,158,760,000.00

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations (BHSA Funding Only)	\$ 286,098,000.00	\$ 333,781,000.00	\$ 333,781,000.00	\$ 953,660,000.00
Transfers From PR Into Component	\$ -	\$ -	\$ -	\$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	\$ 47,507,000.00	\$ 138,570,000.00	\$ 758,079,000.00	\$ 944,156,000.00
Estimated Total Available Funding for Year Two	\$ 333,605,000.00	\$ 472,351,000.00	\$ 1,091,860,000.00	\$ 1,897,816,000.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Two Expenditures	\$ 244,870,000.00	\$ 295,085,000.00	\$ 675,143,000.00	\$ 1,215,098,000.00
BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals
Estimated New Year Three Component Allocations (BHSA Funding Only)	\$ 303,702,000.00	\$ 354,319,000.00	\$ 354,319,000.00	\$ 1,012,340,000.00
Transfers From PR Into Component	\$ -	\$ -	\$ -	\$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	\$ 88,735,000.00	\$ 177,266,000.00	\$ 416,717,000.00	\$ 682,718,000.00
Estimated Total Available Funding for Year Three	\$ 392,437,000.00	\$ 531,585,000.00	\$ 771,036,000.00	\$ 1,695,058,000.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Three Expenditures	\$ 271,865,000.00	\$ 305,453,000.00	\$ 610,949,000.00	\$ 1,188,267,000.00
BHSA Plan Admin Expenses				
Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	\$ 17,589,420.00	\$ 19,738,080.00	\$ 20,944,440.00	\$ 58,271,940.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 13,012,000.00	\$ 13,506,000.00	\$ 13,938,000.00	\$ 40,456,000.00
Total Projected New and Ongoing Administrative Expenditures	\$ -	\$ -	\$ -	\$ -

Behavioral Health Director Certification

Certification

1. I hereby certify that has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:
 - The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
 - I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
 - The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
 - Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
 - BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
 - The IP was submitted to the local behavioral health board
2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
 - Yes
 - No

- a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

Los Angeles

4. Certification for

- Three-Year Integrated Plan
 Annual Update
 Intermittent Update

- 4a. Submission type

- Draft
 Final

5. County Behavioral Health Agency Director name

Lisa H. Wong, Psy.D.

6. County Behavioral Health Agency Director phone number

(213) 947-6670

7. County Behavioral Health Agency Director email

lwong@dmh.lacounty.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

Gary Tsai

9. Title

Director, Substance Abuse Prevention and Control Bureau; Los Angeles County Department of Mental Health

10. Phone

gtsai@ph.lacounty.gov

11. Email

gtsai@ph.lacounty.gov

County Behavioral Health Agency Director signature

12. Print name

Lisa H. Wong, Psy.D.

13. Title

Director, Los Angeles County Department of Mental Health

14. Date

1/7/2026

15. Signature

Lisa H. Wong

Digitally signed by Lisa H. Wong
Date: 2026.01.07 13:28:30 -0800

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

Gary Tsai

17. Title

Director, Substance Abuse Prevention and Control Bureau; Los Angeles County Department of Mental Health

18. Date

1/13/26

19. Signature

Gary Tsai

Digitally signed by Gary Tsai
Date: 2026.01.13 17:06:51 -0800



County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:

- The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
- Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
- BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

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

- Yes
- No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

Signature

3. Print name

Joseph M. Nicchitta

4. Date

January 30, 2026

5. Signature

Joseph Nicchitta
Joseph Nicchitta (CA# 10, 2008 12 13 14 15 16 17)

Contact information

6. County Name

Los Angeles

7. Certification for

- Three-Year Integrated Plan
- Annual Update
- Intermittent Update

7a. Submission type

- Draft

8. County Chief Administration Officer Name

Joseph M. Nicchitta, Acting Chief Executive Officer

9. County Chief Administration Officer Phone number

213-974-1101

10. County Chief Administration Officer Email

jnicchitta@ceo.lacounty.gov



Board of Supervisors Certification

Certification

1. Board of Supervisors certifies the following:

Board of Supervisors has reviewed and approved this Integrated Plan for the period of

County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists

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

Yes

No

- a. If answered yes above, please describe any implementation challenges or concerns with their realignment obligations (optional)

Signature

3. Printed name

4. Title

5. Date

6. Signature

DRAFT

**BOARD LETTER/MEMO
CLUSTER FACT SHEET**

Board Letter

Board Memo

Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input checked="" type="checkbox"/> All <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Mental Health (DMH)	
SUBJECT	Request adoption of a resolution approving the Performance Contract with the State of California, Department of Health Care Services (DHCS) to allow Los Angeles County Department of Mental Health's administration of the Behavioral Health Services Act and non-Behavioral Health Services Act (BHSA) programs and oversight of the provision of community mental health services pursuant to the Bronzan-McCorquodale Act, and the Substance Use Prevention, Treatment, and Recovery Services Block Grant administered by the Angeles County Department of Public Health (DPH).	
PROGRAM	DMH Various Programs	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain why:	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Not Applicable If unsure whether a matter is subject to the Levine Act, email your packet to EOLevineAct@bos.lacounty.gov to avoid delays in scheduling your Board Letter.	
DEADLINES/ TIME CONSTRAINTS	6/9/26	
COST & FUNDING	Total cost: Not applicable	Funding source: Not applicable
	TERMS (if applicable): FY 2026-27 to 2028-29 with two one-year optional extensions	
	Explanation:	
PURPOSE OF REQUEST	Approval and execution of the Performance Contract is necessary for DMH and DPH to continue to administer BHSA, non BHSA, and SUBG programs and receive reimbursement from DHCS for these programs.	
BACKGROUND (include internal/external issues that may exist including any related motions)	<p>In March 2024, voters passed Proposition 1, a transformation of California's behavioral health system, from Mental Health Services Act to BHSA. The BHSA addresses the current behavioral health system and reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders, expanding housing interventions, and increasing the behavioral health workforce. The BHSA also creates pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs.</p> <p>Through this new Performance Contract, DMH will administer the BHSA, non-BHSA programs, and oversee the provision of community mental health services to eligible Medi-Cal beneficiaries of Los Angeles County.</p>	
EQUITY INDEX OR LENS WAS UTILIZED	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain how: Intervene Early and Emphasize Long Term Prevention. The Performance Contract will allow DMH to continue to administer the BHSA and non BHSA programs to address current behavioral health system to prioritize services for people with the most significant mental health needs for families and communities while adding housing interventions and increasing the behavioral health workforce.	

SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state which one(s) and explain how: Priority 1 Child Protection; Priority 3 Care First, Jails Last; Priority 4 Homeless Initiative, and Priority 8 Anti-Racism, Diversity, and Inclusion. These Priorities allow DMH to provide specialty mental health and support to vulnerable populations, including children and youth; families; residents experiencing mental health crisis; residents experiencing homelessness and/or at risk of becoming homeless, and residents involved in/at-risk of becoming involved with the justice system.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Stella Krikorian, Administrative Services Division Manager, (213) 943-9146, skrikorian@dmh.lacounty.gov DMH: Jaclyn Baucum, Sr. Deputy Director, (213) 943-8387, jbaucum@dmh.lacounty.gov Senior Deputy County Counsel: Rachel Kleinberg, (213) 974-7735, RKleinberg@counsel.lacounty.gov



DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

**ADOPT A RESOLUTION TO APPROVE THE PERFORMANCE CONTRACT WITH
THE STATE OF CALIFORNIA, DEPARTMENT OF HEALTH CARE SERVICES FOR
FISCAL YEARS 2026-27, 2027-28, AND 2028-29
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

SUBJECT

Request adoption of a resolution approving the Performance Contract with the State of California, Department of Health Care Services to allow Los Angeles County Department of Mental Health's administration of the Behavioral Health Services Act and non-Behavioral Health Services Act programs and oversight of the provision of community mental health services pursuant to the Bronzan-McCorquodale Act, and the Substance Use Prevention, Treatment, and Recovery Services Block Grant administered by the Los Angeles County Department of Public Health.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Adopt and instruct the Chair of your Board to sign and execute a resolution (Attachment I) approving the Performance Contract No. 26-60037, substantially similar to (Attachment II) with the State of California (State) Department of Health Care Services (DHCS).
2. Approve and authorize the Director of Mental Health (Director), or designee, to sign and execute the Performance Contract No. 26-60037 (Attachment II) with DHCS for the Department of Mental Health's (DMH) administration of the Behavioral Health Services Act (BHSA), non-BHSA programs (Projects for Assistance in Transition from Homelessness, Community Mental Health Services Block Grant, Laura's Law, Crisis Counseling Assistance and Training Program, Lanterman-Petris-Short Act), and the

provision of community mental health services pursuant to the Bronzan-McCorquodale Act, for the provision of specialty mental health services to eligible Medi-Cal members of Los Angeles County and for the receipt of federal and State funds for Fiscal Years (FY) 2026-27, 2027-28, and 2028-29, with two one-year optional extension periods through FY 2030-31. The Performance Contract will be effective July 1, 2026. There is no dollar amount associated with the Performance Contract; however, DMH and DPH must meet certain State and federal requirements in order to receive the designated funding for the programs and community mental health services listed in the Performance Contract.

3. Delegate authority to the Director, or designee, to sign future amendments to the Performance Contract, provided that any such amendment is necessary to: 1) extend the term; 2) reflect revisions required by DHCS and/or revisions requested by either party to the terms and conditions; and/or 3) revise, add, delete, or modify Contract language or other items, including the Scope of Work (SOW), with any such amendment subject to prior review and approval as to form by County Counsel and written notice to the Board and the Chief Executive Office.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval and execution of the Performance Contract is necessary for DMH and Department of Public Health (DPH) to continue to administer their respective programs and receive reimbursement for these programs. The Performance Contract does not include a contract amount. However, DMH and DPH must meet certain statutory requirements to receive funding for these programs and community mental health services other than Medi-Cal. These requirements include those relating to audits, record retention, outcomes, and program principles set forth in the Bronzan-McCorquodale Act.

Board approval of Recommendations 1 and 2 will adopt the required resolution and authorize the Director, or designee, to execute the Performance Contract with the DHCS for the administration of the BHSA, non-BHSA programs, and oversee the provision of community mental health services to eligible Medi-Cal beneficiaries of Los Angeles County.

Board approval of Recommendation 3 will allow DMH to sign future amendments to the Performance Contract to extend the term; reflect revisions by DHCS and/or revisions requested by either party to the terms and conditions; and/or modify the contract language, SOW, or other items.

Implementation of Strategic Plan Goals

These recommended actions are consistent with the County's Strategic Plan Goals, North Star 1, Make Investments that Transform Lives, Focus Area Goal A., Healthy Individuals and Families.

FISCAL IMPACT/FINANCING

There is no dollar amount associated with the Performance Contract. Approval of the Performance Contract will allow DMH to administer and receive the designated funding for BHSA and non BHSA programs, the provision of community mental health services, and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) by DPH provided that both departments meet the State and federal requirements for the programs.

Funding for the mental health programs under the Performance Contract for FY 2026-27 is included in DMH's Budget. Funding for future fiscal years will be included in DMH's annual budget process.

Funding for the SUBG under the Performance Contract for FY 2026-27 is included in DPH's Budget. Funding for future fiscal years will be included in DPH's recommended budget process.

There is no net County cost impact associated with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Performance Contract No. 26-60037 is entered into in accordance with Welfare and Institutions (W&I) Code Sections 5650(a), 5651, and 5897. W&I Code Sections 5614, 5650, 5651, 5717(b), 5897, 5963.04, 14124.2(a), and 14197.7 also authorize DHCS to monitor the County's compliance with statutory conditions and requirements in order to receive funding for BHSA, non BHSA programs, and SUBG.

In March 2024, voters passed Proposition 1, a transformation of California's behavioral health system, from Mental Health Services Act to BHSA. The BHSA addresses the current behavioral health system and reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders, expanding housing interventions, and increasing the behavioral health workforce. The BHSA also creates pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs.

The Honorable Board of Supervisors
June 9, 2026
Page 4

Additionally, the primary goals of the BHSA are to improve access to care, increase accountability and transparency for publicly funded at the state and local levels, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California. Through this new Performance Contract, DMH will administer the BHSA, non-BHSA programs, and oversee the provision of community mental health services to eligible Medi-Cal beneficiaries of Los Angeles County.

Attachment II, Performance Contract No. 26-60037 has been reviewed and approved as to form by County Counsel.

CONTRACTING PROCESS

State regulations require a contractual agreement between the State and the County for the County's administration of the BHSA, non-BHSA programs, and oversight of community mental health services. The Performance Contract is required by W&I Code Sections 5650(a), 5651, and 5897.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board approval of the recommended actions will allow DMH and DPH to administer the BHSA, non-BHSA programs, and SUBG and receive funding for these programs; and oversee the community mental health services. The funding will assist people with serious behavioral health needs with housing and provide a path to long-term recovery.

CONCLUSION

DMH requires the executed resolution (Attachment I) signed by your Board Office. Upon adoption of the Board letter, DMH will request from your Board Office an electronic version of the signed resolution.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:RH:KN:SK:DO:atm

Attachments (2)

The Honorable Board of Supervisors
June 9, 2026
Page 5

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

**RESOLUTION OF
THE BOARD OF SUPERVISORS OF
COUNTY OF LOS ANGELES
STATE OF CALIFORNIA**

NOW, THEREFORE BE IT RESOLVED that the Board of Supervisors (Board) of the County of Los Angeles (County) does hereby approve and authorize the Director Department of Mental Health (Director) or designee to sign the Performance Contract No. 26-60037 entered into by and between the County and the State of California, Department of Health Care Services. It is further resolved that the Board approves and authorizes the Director, or designee, to sign future Amendments or modifications, including optional extensions, to the Performance Contract No. 26-60037.

EDWARD YEN,
Executive Officer-Board of Supervisors of
the County of Los Angeles

By _____
Chair, Board of Supervisors

By _____
Deputy

APPROVED AS TO FORM:
DAWYN R. HARRISON,
COUNTY COUNSEL
OFFICE OF THE COUNTY COUNSEL

By  _____
Rachel Kleinberg
Senior Deputy County Counsel

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT

STD 213 (Rev. 04/2020)

AGREEMENT NUMBER 26-60037	PURCHASING AUTHORITY NUMBER (If Applicable)
-------------------------------------	---

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME

Department of Health Care Services

CONTRACTOR NAME

County of Los Angeles

2. The term of this Agreement is:

START DATE

July 1, 2026

THROUGH END DATE

June 30, 2029

3. The maximum amount of this Agreement is:

\$0 (Zero Dollars)

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of the Agreement.

Exhibits	Title	Pages
Exhibit A	Scope of Work	4
Exhibit A, Attachment I	Behavioral Health Services Act	34
Exhibit A, Attachment II	Additional Terms and Conditions	6
Exhibit A, Attachment III	Request for Waiver	1
Exhibit B	Budget Detail Provisions	1
Exhibit C *	General Terms and Conditions (GTC 02/2025)	Online
Exhibit D	Special Terms and Conditions – (Subsection Section 11.j is not applicable to this Contract.)	40
Exhibit E	Additional Provisions	5
Exhibit F	Business Associate Addendum (HIPAA)	6

Items shown with an asterisk (), are hereby incorporated by reference and made part of this agreement as if attached hereto.*

These documents can be viewed at <https://www.dgs.ca.gov/OLS/Resources>

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)

County of Los Angeles

CONTRACTOR BUSINESS ADDRESS

510 S. Vermont Ave., 22nd Floor

CITY

Los Angeles

STATE

CA

ZIP

90020

PRINTED NAME OF PERSON SIGNING

TITLE

CONTRACTOR AUTHORIZED SIGNATURE

DATE SIGNED

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT

STD 213 (Rev. 04/2020)

AGREEMENT NUMBER 26-60037	PURCHASING AUTHORITY NUMBER (If Applicable)
------------------------------	---

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME

Department of Health Care Services

CONTRACTING AGENCY ADDRESS

1501 Capitol Avenue, MS 4200

CITY

Sacramento

STATE

CA

ZIP

95814

PRINTED NAME OF PERSON SIGNING

TITLE

CONTRACTING AGENCY AUTHORIZED SIGNATURE

DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL

EXEMPTION (If Applicable)

Exempt per Budget Act 2025, Assembly Bill 227, Item 4260-116-0890; Welfare and Institution Code, Sections 5402(i), 5706, and 5814(g).

Exhibit A
SCOPE OF WORK

I. Service Overview

The California Department of Health Care Services (hereafter referred to as DHCS) administers the Behavioral Health Services Act, Lanterman-Petris-Short (LPS) Act, Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Services Block Grant (MHBG), Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), and Crisis Counseling Assistance and Training Program (CCP), and oversees county provision of community mental health services pursuant to the Bronzan-McCorquodale Act.

Contractor (hereafter referred to as County) must meet certain conditions and requirements to receive funding for these programs and services, as set forth in this County Performance Contract (hereafter referred to as the Contract or Agreement), as required by Welfare and Institutions Code (W&I) sections 5650(a), 5651, and 5897. County agrees to comply with all of the conditions and requirements described herein.

DHCS will monitor this Contract to ensure compliance with applicable federal and State law and applicable regulations. (California Government Code (GC), §§ 11180-11182; W&I §§ 5614, 5717(b), 5651(b)(10), 5897(d), 5963.04, 14124.2(a), and 14197.7.)

County must submit all deliverables required in this Contract in the schedule, form, and manner specified by DHCS.

II. Service Location

The services must be performed at the Contractor's work site unless specified via writing to the DHCS Contract Manager.

III. Service Hours

The services must be provided during the Contractor's normal working hours, 8:00AM – 5:00PM, Monday through Friday, unless specified via writing to the DHCS Contract Manager.

IV. Contract Representatives

A. The Contract representatives during the term of this Contract will be:

<p>Department of Health Care Services</p> <p>Contract Manager: Waheeda Sabah</p> <p>Telephone: 916-345-7462</p> <p>Email: waheeda.sabah@dhcs.ca.gov</p>	<p>County of Los Angeles</p> <p>Lisa H. Wong, Psy.D. Director of Mental Health</p> <p>Los Angeles County Department of Mental Health 510 S. Vermont Ave., 22nd Floor Los Angeles, CA 90020</p> <p>Telephone: (213) 947-6670 Email: lwong@dmh.lacounty.gov</p>
--	--

B. Direct all inquiries to:

<p>Department of Health Care Services</p> <p>Behavioral Health – Community Services Division/Federal Grants Branch</p> <p>Attention: Waheeda Sabah 1501 Capitol Avenue P.O. Box Number 997413, Mail Stop 2624 Sacramento, CA 95899-7413</p> <p>Telephone: (916) 345-7462 Email: waheeda.sabah@dhcs.ca.gov</p>	<p>County of Los Angeles</p> <p>Attention: Stella Krikorian Division Manager of Contracts</p> <p>Los Angeles County Department of Mental Health</p> <p>510 S. Vermont Ave., 20th Floor Los Angeles, CA 90020</p> <p>Telephone: (213) 943-9146 Email: skrikorian@dmh.lacounty.gov</p>
---	--

C. Either party may make changes to the information in provision 4 of this Exhibit A by giving written notice to the other party. Said changes will not require an amendment to this Contract.

V. General Requirements for Agreement

W&I section 5651(b) sets forth specific assurances that must be incorporated into this Contract. County must:

A. Comply with the expenditure requirements of W&I section 17608.05;

- B. Provide services to persons receiving involuntary treatment as required by the LPS Act (commencing with W&I section 5000) and the Children's Civil Commitment and Mental Health Treatment Act of 1988 (commencing with W&I section 5585);
- C. Comply with all of the requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals, including, but not limited to, the provisions set forth in Chapter 3 of the Bronzan-McCorquodale Act (commencing with W&I section 5700) , and submit cost reports and other data to DHCS in the form and manner determined by DHCS;
- D. Ensure that the Behavioral Health Advisory Board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process pursuant to W&I section 5604.2;
- E. Comply with all provisions and requirements in law pertaining to patient rights;
- F. Comply with all requirements in federal law and regulation, and all agreements, certifications, assurances, and policy letters, pertaining to federally funded mental/behavioral health programs, including, but not limited to, the PATH, MHBG, and SUBG programs;
- G. Provide all data and information set forth in W&I sections 5610 and 5664 ;
- H. If County elects to provide the services described in Chapter 2.5 of the Bronzan-McCorquodale Act (commencing with W&I section 5670), comply with guidelines established for program initiatives outlined in this chapter; and
- I. Comply with all applicable laws and regulations for all services delivered, including all laws, regulations, and guidelines of the Behavioral Health Services Act.

VI. County Behavioral Health Director

- A. County must comply with the organizational requirements of W&I sections 5604 (Behavioral Health Board), 5607, and 5608 (County Behavioral Health Director).
- B. County agrees to notify DHCS immediately if there is any change in the position of the County Behavioral Health Director. County must provide DHCS the contact information for any new County Behavioral Health Director appointed.

VII. Americans with Disabilities Act

County agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 as amended (29 United States Code (USC) § 794d), the Americans with Disabilities Act of 1990 (42 USC § 12101 *et seq.*), and the implementing regulations, including 36 Code of Federal Regulations (CFR) Part 1194 and 28 CFR Part 36, as applicable. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California GC section 7405 codifies section 508 of the Rehabilitation Act of 1973 and its implementing regulations requiring accessibility of electronic and information technology.

VIII. Executive Order N-6-22 – Russia Sanctions

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. "Economic Sanctions" refers to sanctions imposed by the U.S. government in response to Russia's actions in Ukraine, as well as any sanctions imposed under State law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, should the State determine County is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that will be grounds for termination of this Contract. The State must provide County advance written notice of such termination, allowing County at least 30 calendar days to provide a written response. Termination will be at the sole discretion of the State.

IX. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neutral genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

The provision of the services is subject to the provisions set forth in the Exhibits and Attachments appended hereto.

Exhibit A, Attachment I

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1.0 Behavioral Health Services Act

This Article enumerates key County requirements for implementing the Behavioral Health Services Act (BHSA). These requirements are set forth in greater detail in the BHSA County Policy Manual and other applicable DHCS guidance. This Article is executed pursuant to Welfare and Institutions Code (W&I) section 5897.

In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The primary goals of the BHSA are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California.

This Article details County's obligations under the BHSA, including reporting requirements, fiscal policies, and programmatic requirements for BHSA-funded Behavioral Health Services and Supports (BHSS), Housing Interventions, and Full Service Partnership (FSP) programs.

1.1 BHSA: Overview and General Requirements

1.1.1 Overview

- A. County must implement the BHSA consistent with this Contract (which is executed pursuant to W&I section 5897), applicable law and regulations, the BHSA County Policy Manual (hereafter referred to as the BHSA Policy Manual), and other applicable DHCS guidance.
- B. The defined terms enumerated in the BHSA Policy Manual apply to this Contract, except as otherwise provided.
- C. To the extent there is a conflict between the terms of this Contract and any federal or state statute or regulation or DHCS guidance issued pursuant to W&I section 5963.05 (or other applicable bulletin authority), County must comply with the statute, regulation, or guidance, and the conflicting Contract provision will no longer be in effect.
- D. Where a requirement provided or referenced herein has an effective date that differs from the effective date of this Contract, County is required to comply with the requirement as of its applicable effective date (not the effective date of this Contract) unless DHCS guidance provides otherwise.
- E. All terms and conditions set forth in the BHSA Policy Manual are hereby incorporated by reference and made a part of this Contract as if fully set forth herein.

1.1.2 Eligible and Priority Populations

County must comply with BHSA requirements concerning eligibility for and prioritization of services, as described in BHSA Policy Manual section 2.B.3 and any other applicable DHCS guidance.

- A. Eligible Populations
 - 1) County must limit BHSA services to eligible children and youth and eligible adults and older adults, as defined in W&I section 5892(k). BHSA eligible populations are not required to be enrolled in the Medi-Cal program. (W&I § 5892(k)(7)-(8).)
- B. Priority Populations
 - 1) County must prioritize BHSA services to the populations enumerated in W&I section 5892(d).

- 2) County is permitted to offer BHSA services to eligible individuals outside these priority populations.

1.2 Integrated Plan, Annual Updates, and Intermittent Updates

County must develop and submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes and Annual Updates as described in this section. Counties may submit intermittent updates as needed at any time during the IP cycle consistent with BHSA Policy Manual section 3, and any other applicable DHCS guidance. (W&I §§ 5963–5963.03.)

1.2.1 IP Purpose & Contents

- A. Using the IP and budget templates developed by DHCS, County must comply with the requirements in this section and the BHSA Policy Manual chapter 3:
 - 1) Describe its planned BHSA services and programming in accordance with:
 - a. Local data, including using local mental health and substance use disorder (SUD) prevalence data, unmet behavioral health treatment needs data, as well as identifying local health disparities, homelessness point-in-time counts and considering community health improvement plans (W&I § 5963.02(b)(2), (b)(4)); and
 - b. Statewide behavioral health goals and performance measures as described in BHSA Policy Manual section 3.E.6 (W&I § 5963.02(c)(3); BHSA Policy Manual §§ 2.C, 3.D);
 - 2) Report County’s planned activities and projected expenditures for all County Behavioral Health System services within the Behavioral Health Care Continuum for all funding sources (W&I § 5963.02(c)(1-2); BHSA Policy Manual § 3.C); and
 - 3) Ensure County Board of Supervisors approves the IP and certifies that County will meet its realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth W&I section 14197 without utilizing waitlists. (W&I §§ 5963.02(a), (c), 14197; 14197.71(c)(2).)
- B. Joint IP Submissions
 - 1) Counties submitting a joint IP must comply with the requirements in this subsection and the BHSA Policy Manual section 3.E.5. A joint IP means an IP that covers:
 - a. Two or more county behavioral health departments; or

- b. One or more city-operated programs or departments acting jointly with another city-operated program or department or county behavioral health department.
- 2) Special circumstances for joint IPs
- a. Counties that submitted joint three-year plans under the MHSA may continue to submit joint IPs under BHSA.
 - b. The two city-operated mental health authorities receiving funds pursuant to W&I section 5701.5 must submit IPs independently from their counties under BHSA.
 - c. Counties with separate mental health and substance use disorder departments must collaborate on development on the IP and submit one joint IP to their County Board of Supervisors.
- 3) Counties must ensure joint IP is (BHSA Policy Manual § 3.E.5.3):
- a. Approved by the Board of Supervisors for each county represented in the joint IP or other local governing body prior to submission to the Behavioral health Services Oversight and Accountability Commission and DHCS; and
 - b. Includes certification from the joint entity's behavioral health director as described in subsection 1.2.7.D. of this Attachment I.

1.2.2 IP Submission

- A. County must submit a draft IP no later than March 31 and final IP no later than June 30 to DHCS the fiscal year prior to the effective date of the IP in accordance with BHSA Policy Manual sections 3.A.1 and 3.E.
- 1) If County fails to submit a complete draft or final IP by the required deadlines, County will be out of compliance and may be subject to corrective action. (BHSA Policy Manual § 3.E.4.)
 - 2) County must submit draft and final IPs through the DHCS' web-based county portal. (BHSA Policy Manual §§ 3.A, 3.E.4.1.)
 - a. If DHCS requires County to revise the IP, County will have 15 calendar days from the revision notice to address the issues raised by DHCS and resubmit the IP through the county portal. IPs are effective beginning July 1 of the fiscal year the IP covers. DHCS will post County's IP on DHCS' website. (BHSA Policy Manual § 3.E.4.2.)

1.2.3 Exemptions Submissions & Approval

- A. If County seeks an exemption (as described in subsections 1.7.4 (FSP) and 1.8.2 (Housing Interventions) of this Attachment I), County must comply with the requirements in this subsection 1.2.3 and in BHSA Policy Manual section 3.E.3.
- B. County must submit any exemption requests as part of the draft IP, as outlined in subsection 1.2.2, above. To determine local priorities and make the exemption requests responsive to local needs, counties must begin their community planning process, as described in subsection 1.2.6 of this Attachment I, prior to submitting a draft IP with an exemption request. (BHSA Policy Manual § 3.E.3.2.)
- C. DHCS must approve or deny County's exemption request 30 calendar days from receipt of the request. If DHCS does not respond within 30 calendar days, the exemption request will be considered approved. (BHSA Policy Manual § 3.E.3.4.)
- D. If DHCS denies County's exemption request, County may appeal the denial within 30 calendar days of receiving DHCS' denial as described in BHSA Policy Manual section 3.E.3.5.
- E. An approved exemption will only be valid for the duration of the three-year plan. For each subsequent three-year plan submission, County must submit an updated exemption request for DHCS approval. (BHSA Policy Manual § 3.E.3.2.)

1.2.4 Funding Allocation Percentage Changes

- A. Approved funding allocation percentage changes are final and cannot be adjusted again for the duration of the three-year plan, unless an annual change is approved by DHCS due to a state or local emergency. To be granted an annual change, County must demonstrate to DHCS that (BHSA Policy Manual § 6.B.5.1):
 - 1) It is experiencing a state (Government Code (GC), § 8625) or local (GC § 8630) emergency, and
 - 2) The change is necessary because of the emergency.
- B. County may only request an annual change in funding allocation percentages for previously approved funding allocation percentage changes. (W&I § 5892(c)(4)(C).)
- C. County must submit the funding allocation percentage change request in the county portal.

1.2.5 Annual Updates and Intermittent Updates

- A. County must submit annual updates to the IP in the second and third years of the IP cycle. (W&I § 5963.02(a); BHSA Policy Manual § 3.A.3.)
- B. County may prepare intermittent updates to the IP at any time during the IP cycle, although County must notify DHCS prior to submitting intermittent updates. (BHSA Policy Manual § 3.A.3.)
- C. County must include a summary and justification of the changes made by the annual updates and intermittent updates for a 30-day comment period prior to the effective date of the updates. (W&I § 5963.03(c)(2)(B); BHSA Policy Manual § 3.A.3.)
- D. Annual updates and intermittent updates are not subject to the stakeholder engagement requirements outlined in subsection 1.2.6 of this Attachment I. (W&I § 5963.03(a).) However (BHSA Policy Manual § 3.A.3):
 - 1) DHCS encourages stakeholder engagement; and
 - 2) If County chooses to elicit local stakeholder engagement in developing annual updates or intermittent updates, County must comply with the local behavioral health public hearing requirements outlined in subsection 1.2.7 of this Attachment I. (W&I § 5963.03(b)(1).)
- E. Submission and DHCS Review
 - 1) County must submit annual updates and intermittent updates using the DHCS' templates and web-based portal.
 - 2) Annual updates and intermittent updates are subject to the same process for submission and DHCS review as the IP, as described above in subsection 1.2.1 of this Attachment I.

1.2.6 Community Planning Process

- A. In developing the IP, County must conduct the following Community Planning Process activities (W&I § 5963.03(a); BHSA Policy Manual § 3.B):
 - 1) Engage local stakeholders in developing each element of the IP, as described in BHSA Policy Manual section 3.B.1 (W&I § 5963.02(b)); and
 - 2) Collaborate and engage with Medi-Cal Managed Care Plans (MCPs) and Local Health Jurisdictions (LHJs) as described in BHSA Policy Manual section 3.B.2, including by:

- a. Working with its LHJ on the development of the Community Health Improvement Plan (CHIP) (W&I § 5963.01(b));
 - b. Considering the CHIP of each LHJ that covers residents of the County in preparing County's IP and annual update (W&I § 5963.02(b)(4));
 - c. Working with each MCP that covers residents of the County on the development of the MCP's Population Needs Assessment (PNA) (W&I § 5963.01(a)); and
 - d. Considering the PNA of each MCP that covers residents of the County in preparing County's IP and annual update. (W&I § 5963.02(b)(3).)
- B. In implementing this subsection 1.2.6, County must:
- 1) Engage with LHJs and MCPs on Community Health Assessments (CHAs) and CHIPs through collaboration, data-sharing, and stakeholder engagement as described in BHSA Policy Manual section 3.B.2.3.
 - 2) Refer to the statewide behavioral health goals and associated performance measures during the community planning process, as described in BHSA Policy Manual section E.6.

1.2.7 Public Comment

For each draft IP, County must comply with the public comment and update processes outlined in this section, as applicable, and the requirements specified in BHSA Policy Manual sections 3.B.3 and 3.E.2.1.2 (W&I § 5963.03(a)-(b)):

- A. Provide 30 days for stakeholder comment, which may be conducted before or after County submits its draft IP to DHCS (W&I § 5963.03(a)(2)(B));
- B. After the 30-day comment period, require the local behavioral health board to (W&I § 5963.03(b), (d)):
 - 1) Review the draft plan and make recommendations to the local behavioral health agency for revisions (W&I § 5963.03(b).); and
 - 2) Provide an annual report to the local governing body (the local Board of Supervisors or city council) and to DHCS that includes written explanations in response to any substantive recommendations made by the local behavioral health board that are not included in the final IP or annual or intermittent updates. (W&I § 5963.03(d), (b)(5).)

- C. After the 30-day comment period and public hearing are complete, County must revise the IP to include (W&I § 5963.03(b)((2)-(3)):
 - 1) A summary of substantive written recommendations; and
 - 2) A summary and analysis of the revisions made as a result of stakeholder feedback.
- D. County must receive approval from County's Board of Supervisors and certification from County's Behavioral Health Director prior to submitting the final IP. (BHSA Policy Manual § 3.E.2.1.2.)

1.2.8 County Planning Funds

- A. County may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs, pursuant to the requirements set forth in subsection 1.4 of this Attachment I. (W&I § 5892(e)(1)(B)-(C); BHSA Policy Manual § 3.B.4; Behavioral Health Information Notice (BHIN) 25-016.) Eligible planning costs do not include costs incurred as administrative costs or program expenditures.

1.3 Behavioral Health Outcomes, Accountability, and Transparency Report

County must develop and submit an annual Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) to DHCS, consistent with BHSA Policy Manual section 4 and any other applicable DHCS guidance. (W&I § 5963.04.)

1.3.1 BHOATR Purpose, Contents and Submission

- A. Using the BHOATR and expenditure templates developed by DHCS, County must:
 - 1) Report on behavioral health spending, service utilization, and achievement of goals and outcomes outlined for the reporting period (W&I § 5963.04(a); BHSA Policy Manual §§ 3.C, 4); and
 - 2) Ensure County Board of Supervisors approves the BHOATR and certifies that County will meet its realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth W&I section 14197 without utilizing waitlists. (W&I § 5963.04(b)-(c), 14197.71(c)(2).)
- B. County must submit the BHOATR through DHCS' web-based county portal.

- C. DHCS must post County's BHOATR and an aggregated statewide BHOATR on DHCS' website. (W&I § 5964.04(d); BHSAPolicy Manual § 4.A.)

1.4 BHSAPolicy Fiscal Policies

County must establish a local BHSF, appropriately allocate funding, and comply with related reporting requirements consistent with BHSAPolicy Manual section 6.B and any other applicable DHCS guidance. (W&I § 5892.)

1.4.1 Allocation Methodology

- A. County must establish a local BHSF for the monthly distribution of funds from the State Controller's Office. (W&I §§ 5892(g), 5891(c); BHSAPolicy Manual § 6.B.1.)
- B. County must establish and maintain sub-accounts for each BHSAPolicy component (Housing Intervention Programs, FSP Program, and BHSS). County is encouraged to maintain sub-accounts for each suballocation under each BHSAPolicy component, as described in BHSAPolicy Manual section 6.B.1.1.
- C. County must allocate and spend funds consistent with the proposed activities and projected expenditures approved in County's IP, intermittent updates, and/or annual update. (W&I § 5892(h); BHSAPolicy Manual § 6.B.1.1.)

1.4.2 Local Prudent Reserve

County must (BHSAPolicy Manual § 6.B.3):

- A. Establish and maintain a local Prudent Reserve (PR) to ensure BHSAPolicy components are not significantly impacted during years where revenues for the BHSF are below recent averages adjusted by changes in the state population and the California Consumer Price Index, as determined by DHCS. During such periods, County may transfer funds out of the PR in accordance with this Attachment I and BHSAPolicy Manual section 6.B.3. (W&I § 5892(b)(1).) County may draw down PR funds only during periods in which DHCS has determined that state-level BHSF revenues are below recent trends.
- B. Assess PR funding levels at least once every three years. County must report PR assessments in the IP and must ensure each PR assessment is certified by County's Behavioral Health Director in the county portal. (W&I § 5892(b)(5).)
- C. Not exceed the maximum PR levels calculated by DHCS.

- D. Spend excess funds on BHSA components as outlined in subsection 1.4.1.A if County exceeds the PR allowable maximum. (W&I § 5892(b)(1), (b)(3)-(5).)
- E. Not count funds placed in the PR toward its required BHSA component allocations. Counties may transfer funds from their monthly disbursement to their local PR after allocating the required amount of funds to each component. (W&I § 5892.)
- F. Report all PR transfers and expenditures in the BHOATR.

1.4.3 Funding Component Allowances

County must comply with the following funding allocation and suballocation requirements, unless County receives approval for a funding transfer (in accordance with subsection 1.4.4, below) or exemption (in accordance with subsections 1.7.4 (FSP) and 1.8.2 (Housing), below). (W&I § 5892(a); BHSA Policy Manual § 6.B.5.)

- A. County must allocate funding for BHSA components and suballocations according to the following requirements:
 - 1) Thirty percent for Housing Intervention Programs. Within this thirty percent (W&I § 5892(a)(1)(A)):
 - a. A minimum of fifty percent must be spent on housing interventions for persons who are chronically homeless with a focus on those in encampments; and
 - b. A maximum of twenty-five percent may be spent on Capital Development Projects.
 - 2) Thirty-five percent for the FSP Program (W&I § 5892(a)(2)(A)); and
 - 3) Thirty-five percent for BHSS, including (W&I § 5892(a)(3)(A), (a)(3)(B)(i)-(ii)):
 - a. A minimum of fifty-one percent exclusively for early intervention programs, of which at least fifty-one percent must be used to serve individuals 25 years of age and younger. Services provided as part of an early intervention evidence-based practices (EBPs) or community-defined evidence-based practices (CDEPs) that supports parents and caregivers may count towards the percentage to be used to service individuals 25 years of age and younger when they are provided for the benefit of that child/youth. (BHSA Policy Manual § 7.A.7.)

1.4.4 Funding Transfer Requests

County may request permission from DHCS to change required funding allocation percentages by transferring BHSA funds between BHSA components, in accordance with BHSA Policy Manual section 6.B.4. (W&I § 5892(c).)

- A. County's approved funds transfers between BHSA components are final and cannot be adjusted for the three-year duration of the IP, unless an annual change is approved by DHCS due to a state or local emergency pursuant to W&I section 5892(c)(4)(C).
 - 1) County may modify its budgeted projected expenditures for the suballocations within a component without advance DHCS approval as part of an annual or intermittent update, in accordance with subsection 1.2.5.E, above. However, County must continue to abide by the suballocation requirements described in subsection 1.4.3, above.
- B. County must report approved transfers and updated BHSA allocations on the BHOATR, consistent with the transfers and exemptions approved as part of the IP. (W&I § 5963.04(a).)
- C. Transferring funds between BHSA components, pursuant to an approved funding transfer request under this subsection 1.4.4, does not reset or extend the original reversion period. All transferred funds remain subject to the same reversion period that applied based on the fiscal year in which the funds were originally allocated.
- D. County's funding transfer requests are not exempt from:
 - 1) Suballocation requirements or any other additional applicable laws, including as described in subsection 1.4.3 of this Attachment I (W&I § 5892(c)(2));
 - 2) Local stakeholder consultation requirements (W&I § 5892(c)(3)); and
 - 3) Reversion requirements, including the reversion period associated with the funds prior to the transfer. (W&I § 5892(i).)
- E. County must submit transfer requests to DHCS prior to or at the same time as County's IP submission using DHCS' web-based county portal and must report all approved transfer requests on the IP. (W&I § 5892(c)(4).) Transfer requests must be approved by DHCS prior to the beginning of the fiscal year in which the requested changes would take effect.

1.4.5 Reversion Policy

County must spend BHSA funds allocated to BHSA components within three years for large counties, or within five years for small counties, as described in

BHSA Policy Manual section 6.B.6.2. Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) funds must be spent within ten years, regardless of county size. (BHSA Policy Manual § 6.B.6.)

- A. For purposes of this Attachment I, a small county is defined as a county with a population of less than 200,000, and a large county is defined as a county with a population of 200,000 or more.
- B. Any BHSA funds remaining after the reversion period must revert to the State. DHCS will offset the amount of reverted funds from the County's future monthly BHSA distribution. (W&I § 5892(i); BHSA Policy Manual § 6.B.6.)
- C. DHCS will provide notice of funds subject to reversion. County may submit an appeal to DHCS if County disagrees with DHCS' determination of the reversion amount. For details, see BHSA Policy Manual sections B.6.5-9. (W&I § 5892.1(b)(2).)

1.4.6 Mental Health Services Act to Behavioral Health Services Act Transition

- A. County must only use BHSF dollars for permissible BHSA purposes. County must not allocate BHSF funds to any of the following activities, notwithstanding that these activities represented permissible uses of funds under the MHSA (W&I § 5892(a)(1)-(3); BHSA Policy Manual § 6.B.7):
 - 1) Community Services and Supports
 - 2) Prevention and Early Intervention
 - 3) Innovation (INN) funds (BHSA Policy Manual § 6.B.7.2)
 - a. If County has INN funds that were encumbered prior to July 1, 2026, and the INN project is operational, meaning that County has spent any funds on the INN project prior to July 1, 2026, those INN funds will remain encumbered for the duration of the FY 2026-29 IP.
 - b. If County's INN funds are encumbered in a previously approved INN project, but that project is not operational as of July 1, 2026, those funds will be disencumbered and may be subject to reversion.
 - c. County must report all INN projects, including which INN projects are operational, in the IP and expenditures in the BHOATR.
- B. If County has unspent MHSA funds as of July 1, 2026, County may allocate those funds to BHSA components, subject to compliance with applicable BHSA requirements, including:

- 1) Allocation and suballocation requirements for each BHSA component as outlined in subsection 1.4.3 of this Attachment I;
 - 2) BHSA component requirements as outlined in subsections 1.6, 1.7, and 1.8 of this Attachment I; and
 - 3) Reversion requirements as outlined in subsection 1.4.5 of this Attachment I except for INN Funds.
- C. County's MHSAs funds for WET and CFTN must remain available for WET and CFTN expenditures within the BHSS component. (BHSA Policy Manual §§ 6.B.7.3, 6.B.7.6.)
- 1) MHSAs WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to BHSA suballocation requirements.
 - 2) All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN.
- D. Any unspent MHSAs funds transferred to the BHSS remain subject to their original revision periods. (BHSA Policy Manual §§ 6.B.7.3, 6.B.7.6.)

1.4.7 Administrative Cost Principles

County may claim reimbursement for administrative costs in accordance with BHSA Policy Manual section 6.B.8 and BHIN 25-016.

- A. Administrative costs are costs that support the operations and overhead of County's behavioral health programs. Administrative costs for BHSA do not include costs incurred as planning costs (outlined in subsection 1.2.8 of this Attachment I and BHSA Policy Manual section 3.B.4) or service expenditures.
- B. County may use a portion of local BHSA revenue towards direct and indirect administrative costs.
- 1) Administrative costs include expenses related to improving planning, quality outcomes, data reporting, and subcontract oversight for County's behavioral health programs, including programs other than BHSA. Administrative costs are capped at two percent for large counties and four percent for small counties. (W&I § 5892(e)(2)(B).)
 - 2) Administrative costs do not include expenditures incurred as direct service costs or as planning costs related to development of the IP. Planning costs for the IP are subject to a separate five percent cap, as outlined in subsection 1.2.8 of this Attachment I. (W&I § 5892(e)(1)(B)-(C); BHSA Policy Manual § 3.B.4.)

- 3) Counties may submit claims for reimbursement of certain direct administrative costs in excess of these caps pertaining to preparing and submitting the IP or BHOATR, or to information technology system enhancements, as described in BHIN 25-016.
- C. County must report all administrative costs in the IP and BHOATR, and must report such costs consistent with 2 Code of Federal Regulations (CFR) section 200. (W&I § 5963.04(a)(2)(F); BHSA Policy Manual § 6.B.8.1.)
- D. For indirect administrative costs, County must charge indirect costs to a BHSA program through an acceptable allocation method that allocates the costs of support and administrative services to the benefiting programs, in accordance with 2 CFR part 200 and BHSA Policy Manual section 6.B.8.2.2.

1.5 Promoting Access to Care through Efficient Use of State and County Resources

1.5.1 Overview

Effective July 1, 2027, County must comply with the requirements set forth in this subsection 1.5, BHSA Policy Manual section 6.C, and any other applicable DHCS guidance. These requirements apply with respect to all BHSA-funded providers (including contracted providers as well as providers employed, owned, or operated by County) delivering a BHSA-funded service that is also covered by, as applicable (W&I § 5891(a)(2)-(3)):

- A. County's Medi-Cal Behavioral Health Delivery System (BHDS) (i.e., the county's administration of Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and/or DMC Organized Delivery System (DMC- ODS) services);
- B. An MCP; or
- C. Commercial health insurance.

1.5.2 Medi-Cal BHDSs

For any provider receiving BHSA funding for services that are covered by County's BHDS, County must require the provider to (W&I § 5891(a)(3); BHSA Policy Manual § 6.C.2):

- A. Enroll in Medi-Cal, seek SMHS and/or DMC certification, and participate in County's BHDS, as applicable;
- B. For an individual receiving BHSA-funded services that are also covered by County's BHDS, check whether the individual is enrolled in Medi-Cal, and

if not, refer the individual for eligibility screening and enrollment support;
and

- C. Submit claims to the BHDS for all covered services for all Medi-Cal members.

1.5.3 Medi-Cal MCPs

For any provider receiving BHSA funding for services that are non-specialty mental health services (NSMHS) or SUD services covered by Medi-Cal MCPs, County must require the provider to (W&I § 5891(a)(3)-(4); BHSA Policy Manual § 6.C.2):

- A. Enroll in Medi-Cal;
- B. For an individual receiving BHSA-funded services that are also covered by MCPs, check whether the individual is enrolled in Medi-Cal, and if not, refer the individual for eligibility screening and enrollment support; and
- C. Make a good faith effort to submit claims to MCPs for all covered services for all Medi-Cal members in accordance with each MCP's billing requirements, including obtaining prior authorization, when applicable.

1.5.4 Commercial Health Insurance

For any provider receiving BHSA funding for services that are covered by commercial health insurance, County must require provider to make a good faith effort to meet the following requirements in this subsection 1.5.4. For County-contracted providers, County will meet these requirements if it contractually requires BHSA-funded providers to take the following steps (W&I § 5891(a)(3)-(4); BHSA Policy Manual § 6.C.3):

- A. Check whether individuals receiving BHSA-funded services are enrolled in a commercial health plan at the time the individuals request and receive BHSA-funded service; and if so,
- B. Make a good faith effort to submit claims to commercial health plans for all covered services in accordance with each health plan's billing requirements, including obtaining prior authorization, when applicable.
- C. Report complaints about commercial health plan conduct for failure to contract, enter into agreements, or timely reimburse the county for services.

1.5.5 Appropriate Use of Other Non-Behavioral Health Services Act Funds

County must not use BHSA funds to supplant existing State or County funds that have been used to provide mental health services or SUD treatment services, in accordance with W&I section 5891(a)(1)(B). (BHSA Policy Manual § 6.C.4.)

1.6 Behavioral Health Services and Supports

County must implement BHSA BHSS consistent with BHSA Policy Manual section 7.A and any other applicable DHCS guidance. (W&I § 5892, (a)(3)(A).) BHSS categories include:

1.6.1 Children’s Adult, and Older Adult Systems of Care

County may use a portion of BHSS funds to provide services pursuant to W&I Division 5, Part 4 (commencing with section 5850) for the Children’s System of Care and Part 3 (commencing with section 5800) for the Adult Systems of Care. Children’s, Adult, and Older Adult Systems of Care services funded under BHSS may not include Housing Interventions or services for individuals enrolled in an FSP. (BHSA Policy Manual § 7.A.2.)

1.6.2 Outreach and Engagement

County may use a portion of BHSS funds for Outreach and Engagement. BHSS funds may be used for activities intended to reach, identify, and engage individuals, families, and communities in the behavioral health system and reduce disparities. (BHSA Policy Manual § 7.A.3.)

1.6.3 WET

- A. County may use a portion of BHSS funds for County-operated and County-contracted behavioral health workforce recruitment, development, training, and retention activities. BHSS funds for WET activities must be spent within ten years, after which unspent funds will be subject to reversion. (BHSA Policy Manual § 7.A.4.)
- B. WET activities must supplement, but must 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). (BHSA Policy Manual § 7.A.4.1.)

1.6.4 CFTN

County may use a portion of BHSS funds for CFTN. BHSS CFTN projects include the acquisition and development of land, the construction or renovation of buildings, or the development, maintenance, or improvement of information technology to support behavioral health administration and services. Counties can also use BHSS funds as the required match for Behavioral Health Infrastructure Bond Act of 2023 Program Behavioral Health Continuum Infrastructure Program (BHCIP) awards. BHSS funds for CFTN projects must be spent within ten years, after which unspent funds will be subject to reversion. (BHSA Policy Manual § 7.A.5.)

1.6.5 Innovative Behavioral Health Pilots and Projects

The goal of innovative behavioral health pilots and projects is to build the evidence base for the effectiveness of new statewide strategies. County is encouraged to pilot and test innovative behavioral health pilots and projects in all BHSA funding components (Housing Interventions, FSP, and BHSS). County should fund innovative behavioral health pilots and projects under each of those separate funding components. (BHSA Policy Manual § 7.A.6.)

1.6.6 Early Intervention Programs

County must implement Early Intervention Programs designed to prevent mental illness and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health. (W&I §§ 5840(a)(1), 5892(a)(3)(A)(ii); BHSA Policy Manual § 7.A.7)

- A. County's Early Intervention Program must, as described in BHSA Policy Manual section 7.A.7:
- 1) Emphasize the reduction of the likelihood of suicide and self-harm, incarcerations, homelessness, and the other adverse outcomes enumerated in BHSA Policy Manual section 7.A.7 (W&I § 5840(d));
 - 2) Include culturally responsive and linguistically appropriate interventions;
 - 3) Create critical linkages with community-based organizations;
 - 4) Prioritize funds according to BHSA Policy Manual section 7.A.7.2, including specific interventions focused on childhood trauma (W&I §§ 5840.7; 5840.6(c));
 - 5) Include the following components, as described in BHSA Policy Manual section 7.A.3: outreach, access and linkage to care, and mental health and SUD services and supports (W&I § 5840(b)); and
 - 6) Provide an Early Psychosis Intervention (EPI) Plus Program, which must include a Coordinated Specialty Care for First Episode Psychosis (CSC for FEP) program with fidelity and consistent with the requirements established for BH-CONNECT, as described in BHSA Policy Manual section 7.A.7.5.2. This BHSA requirement applies regardless of whether the County has elected to offer CSC for FEP as a bundled Medi-Cal service.
- B. In addition to CSC for FEP, DHCS may, in the future, identify other EBPs or CDEPs that County is required to implement. (W&I § 5840(c)(5).) County may, in addition, describe in their IP County-specific CDEPs that are not included on DHCS' list of EBPs and CDEPs. (BHSA Policy Manual § 7.A.6.)

1.7 Full Service Partnership

County must implement a BHSA FSP program consistent with BHSA Policy Manual section 7.B and any other applicable DHCS guidance. (W&I § 5887.)

1.7.1 Eligible and Priority Populations

- A. FSP eligible populations include (W&I § 5892(k); BHSA Policy Manual § 7.B.3.1):
 - 1) BHSA eligible adults and older adults who meet the priority population criteria specified in W&I section 5892(d); and
 - 2) BHSA eligible children and youth, including transitional age youth (TAY) ages 16-25.
- B. County must comply with presumptive eligibility requirements set forth in W&I section 5887(d)(2) and any other applicable DHCS guidance.

1.7.2 FSP Levels of Care

County must, as described in BHSA Policy Manual section 7.B.4, ensure that FSP programs have a standard of care, with levels of care using the appropriate EBP to treat individuals based on acuity, based on clinical judgment and discretion reflecting individualized needs. (W&I § 5887(e).)

1.7.3 Program Requirements

- A. County must provide the following BHSA services to FSP participants in accordance with demonstrated clinical need and in alignment with the required FSP levels of care, regardless of whether County's BHDS has opted to provide these services under a Medi-Cal bundled rate (W&I § 5887; BHSA Policy Manual § 7.B):
 - 1) Mental health services, supportive services, and SUD services as described in BHSA Policy Manual section 7.B.3.2;
 - 2) Assertive Community Treatment (ACT) as described in BHSA Policy Manual section 7.B.4.1;
 - 3) Forensic ACT (FACT) as described in BHSA Policy Manual section 7.B.4.1;
 - 4) FSP Intensive Case Management (ICM) under a team-based approach with an identified team lead, as described in BHSA Policy Manual section 7.B.4.2;
 - 5) High Fidelity Wraparound (HFW) as described in BHSA Policy Manual section 7.B.4.3;

- 6) Individual Placement and Support (IPS) model of Supported Employment as described in BHSA Policy Manual section 7.B.5;
 - 7) Assertive field-based initiation for SUD as described in BHSA Policy Manual section 7.B.6;
 - 8) Outpatient behavioral health services for evaluation and stabilization as described in BHSA Policy Manual section 7.B.3.2;
 - 9) Ongoing engagement services as described in BHSA Policy Manual section 7.B.3.2;
 - 10) Service Planning in accordance with the processes in W&I sections 5806 and 5868; County's FSP Program is not required to maintain documentation in a "standalone" treatment plan or service plan; and
 - 11) Housing Interventions, funded under the Housing Interventions category as outlined in subsection 1.8 of this Attachment I.
- B. County FSP teams must be capable of supporting FSP participants living with co-occurring mental health and SUD conditions, as described in BHSA Policy Manual sections 7.B.3.2 and 7.B.3.5.
- C. County may include additional behavioral health services County determines are beneficial to an eligible individual's treatment, if not already covered by ACT, FACT, FSP ICM, or HFW, in collaboration with the individual and, when appropriate, the individual's family. (BHSA Policy Manual § 7.B.3.3.)
- D. County may use FSP funding for outreach activities if the activities relate to enrolling individuals living with significant behavioral health needs in an FSP (W&I § 5887(d).) General outreach to individuals living with significant behavioral health needs who are not FSP eligible should be funded under other appropriate funding sources including BHSS and Housing Interventions. (BHSA Policy Manual § 7.B.3.3.)

1.7.4 FSP Exemptions

- A. For the first IP (covering July 1, 2026, to June 30, 2029), all counties are exempt from the EBP fidelity requirements for ACT, FACT, IPS Model of Supported Employment, and HFW. Counties are still required to begin offering the required FSP EBPs by July 1, 2026, unless a small county receives an exemption under subsection 1.7.4.C, below. (BHSA Policy Manual § 7.B.3.4.)
- B. To meet FSP EBP requirements (between fiscal years 2026-2029), County must (BHSA Policy Manual § 7.B.3.4):
- 1) Participate in ongoing training and technical assistance for all FSP EBPs;

- 2) Understand gaps to fidelity for each FSP EBP by December 31, 2027; and
 - 3) Meet other requirements and implementation milestones as described in BHSA Policy Manual section 7.B.6.
- C. Small counties as defined under subsection 1.4.5.A.1 of this Attachment I and cities submitting an IP independently may request an exemption from the EBP requirements for ACT, FACT, and/or IPS. (W&I § 5887(a)(2); BHSA Policy Manual § 7.B.3.4.) County must request exemptions from each EBP (ACT, FACT, and/or IPS) individually and provide corresponding documentation. Criteria for FSP exemption requests include (BHSA Policy Manual § 7.B.3.4):
- 1) Limited workforce (e.g., qualified providers)
 - 2) Limited need (e.g., the estimated population with a clinical need for an EBP)
 - 3) Other hardships, subject to DHCS' review

1.7.5 FSP EBP Service Capacity and Fidelity Standards

- A. Absent a DHCS-approved exemption, County is required to adhere to EBP requirements and to establish teams of behavioral health practitioners to deliver each FSP EBP, regardless of whether County's Medi-Cal BHDS has opted to cover these services as bundled Medi-Cal services. (BHSA Policy Manual § 7.B.)
- B. County must use the IP and annual update to project the number of full-time equivalent (FTE) practitioners and multidisciplinary teams to provide ACT, FACT, IPS, and HFW between 2026 and 2029. (BHSA Policy § 7.B.6.1.) County must ensure that the projected teams identified comply with the FSP EBP fidelity standards as described in BHSA Policy Manual section 7.B.6.2.

1.8 Housing Interventions

County must implement BHSA Housing Interventions consistent with BHSA Policy Manual section 7.C and any other applicable DHCS guidance. (W&I § 5830.)

1.8.1 Eligible and Priority Populations

- A. County must limit BHSA Housing Interventions component to individuals who (W&I § 5830(a)):
 - 1) Meet BHSA eligibility criteria as defined in subsection 1.1.2 of this Attachment I; and

- 2) Are either at risk of homelessness, experiencing homelessness, or chronically homeless as defined in W&I section 5892(k)(2)-(3) and BHSA Policy Manual section 7.C.4.
- B. Housing Interventions must not (W&I § 5830(a)(2)-(4); BHSA Policy Manual § 7.C.5):
- 1) Be limited to individuals enrolled in FSP;
 - 2) Be limited to individuals enrolled in Medi-Cal; and
 - 3) Discriminate against or deny access to housing for individuals that are utilizing medications for addiction treatment or other authorized medications, or individuals who are justice-involved.
- C. County must prioritize BHSA Housing Interventions to the populations enumerated in BHSA Policy Manual section 7.C.4.2.
- D. For individuals housed under the MHSA as of June 30, 2026, County must comply with the BHSA transition policies outlined in BHSA Policy Manual section 7.C.4.3.
- E. County must ensure that all BHSA Housing Intervention settings are combined with access to clinical and supportive behavioral health care and housing services that will promote the individual's health and functioning and long-term stability. (BHSA Policy Manual § 7.C.5.)

1.8.2 Housing Interventions Exemptions

In accordance with the procedures in BHSA Policy Manual section 7.C.6.2 (W&I § 5892(a)(1)(B)-(C)):

- A. Beginning with the IP covering fiscal years 2026-2029, counties with a population of less than 200,000 and cities submitting an IP independently may request an exemption from the Housing Interventions component allocation and suballocation funding allowances described in subsection 1.4.3 of this Attachment I; and
- B. Beginning with the IP covering fiscal years 2032-2035, all counties regardless of size may request such exemptions.

1.8.3 Relationship to Medi-Cal Funded Housing Services

BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCPs. (W&I § 5830(c)(2); BHSA Policy Manual § 7.C.7.) County must coordinate with MCPs as described in BHSA Policy Manual section 7.C.7 to:

- A. Ensure Housing Interventions are not used for services covered by MCPs;

- B. Support seamless connections from the county to MCPs for coverage of housing services and vice versa; and
- C. Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet eligibility criteria for BHSA.

1.8.4 Allowable Expenditures and Related Requirements

BHSA Housing Interventions may include the following types of expenditures, subject to the program requirements and limitations outlined in this section and BHSA Policy Manual sections 7.C.9 and 7.C.10:

- A. Rental subsidies (BHSA Policy Manual § 7.C.9.1.)
- B. Operating subsidies (BHSA Policy Manual § 7.C.9.2.)
- C. Allowable settings (BHSA Policy Manual § 7.C.9.3.)
 - 1) Non-time-limited permanent settings, including Permanent Supportive Housing (PSH)
 - 2) Time limited interim settings
- D. Other housing supports (BHSA Policy Manual § 7.C.9.4.)
 - 1) Landlord Outreach and Mitigation Funds
 - 2) Participant Assistance Funds
 - 3) Housing Transition Navigation Services and Tenancy and Sustaining Services
 - 4) Outreach and Engagement, up to a limit of seven percent of Housing Interventions
- E. Other Housing Interventions requirements and policies (BHSA Policy Manual § 7.C.9.5)
 - 1) County must ensure Housing Interventions are:
 - a. Operated in compliance with the core components of Housing First (W&I §§ 8255(b), 5830(a)(5));
 - b. Available to support Family Housing, as appropriate; and
 - c. Only used in connection with housing settings that meet minimum standards for habitability and quality.
 - 2) County must operate the Housing Interventions component in accordance with Homeless Management Information System (HMIS) reporting requirements. (W&I § 8256(d)(3)(A).)

- F. Capital development projects, up to a limit of 25 percent of Housing Interventions funding (W&I § 5892(a)(1)(A)(iii); BHSA Policy Manual § 7.C.10.)

1.9 Documentation Requirements for BHSA Services

- A. County must ensure all mental health and SUD services funded under BHSA (with the exception of hospital inpatient and Narcotic Treatment Program services) comply with documentation requirements established in BHIN 23-068. (BHSA Policy Manual § 8.)
- B. Documentation requirements do not apply to services and supports where this approach to clinical documentation requirements may be unsuitable, such as (BHSA Policy Manual § 8):
 - 1) BHSA housing services;
 - 2) Outreach programs, including BHSS Outreach and Engagement and outreach funded under FSP, where gathering identifying information is not feasible (e.g., outreach to homeless individuals and others who are not yet comfortable providing their information);
 - 3) Warm lines and hotlines; and
 - 4) Food support provided under FSP.

1.10 BHSA Oversight and Enforcement

1.10.1 DHCS Oversight and Enforcement

- A. DHCS will conduct compliance reviews to assess County's compliance with BHSA program requirements as required under W&I section 5897(d). The reviews will be conducted as described in BHSA Policy Manual section 9.C.
 - 1) County must comply with DHCS requests for documents and information needed to conduct compliance reviews, including (BHSA Policy Manual §§ 9.C.1-2.):
 - a. Submitting requested documents to DHCS prior to and during the review; and
 - b. Making personnel, including personnel employed by or under contract with County and BHSA-funded providers (including contracted providers and providers employed, owned, or operated by County) available for DHCS to interview.

- B. If DHCS determines that County is out of compliance with BHSA requirements as set forth in State law, applicable DHCS guidance, and this Contract, DHCS may conduct enforcement actions, such as (W&I §§ 5897(e), 5963.04(e), 14197.7; BHSA Policy Manual § 9.D):
- 1) Administrative sanctions, including (W&I § 5963.04(e); BHSA Policy Manual § 9.D.1):
 - a. Imposing a corrective action plan (CAP) as described in BHSA Policy Manual section 9.D.1.1 or requiring County to revise its IP or annual update as described in BHSA Policy Manual section 9.D.1.2.
 - i. Administrative sanctions may be imposed for, among other reasons, failure to make adequate progress in meeting performance measures established by DHCS pursuant to W&I section 5963.04(b). DHCS can exercise this authority outside the standard IP and annual update submission timeline, including after County's BHOATR submission. (BHSA Policy Manual § 9.D.1.2.)
 - 2) Temporary monetary withholds and monetary sanctions. (W&I §§ 5963.04(e)(3), 14197.7(n)(5); BHSA Policy Manual § 9.D.2.)
 - a. DHCS may impose temporary monetary withholds and monetary sanctions, as outlined in BHSA Policy Manual section 9.D.2, if County (W&I § 5963.04(e)(3)):
 - i. Fails to follow stakeholder engagement requirements for the IP or the 30-day comment period for the annual update and intermittent update, as described in W&I section 5963.03 and BHSA Policy Manual section 3.B;
 - i. Fails to allocate BHSA funds in accordance with statutory requirements, as set forth at W&I section 5892 and BHSA Policy Manual section 6.B;
 - ii. Fails to submit a complete, accurate, and timely BHOATR in accordance with W&I section 5963.04 and BHSA Policy Manual chapter 4; or
 - iii. Spends BHSA funds in a manner that significantly varies from its budget in the IP, annual update, or intermittent update.

- C. County may appeal a temporary withhold or monetary sanction imposed pursuant to this subsection 1.10.1.A.2, above. County's appeal will be conducted in accordance with the requirements specified in BHSA Policy Manual section 9.D.2.5 and pursuant to procedures outlined in DHCS guidance. (W&I 14197.7(h), (k)-(m); BHIN 25-023.)

1.10.2 County Oversight

County must comply with BHSA Policy Manual Section 9.E and any other applicable DHCS guidance regarding oversight of BHSA-funded providers (including contracted providers as well as providers employed, owned, or operated by County).

- A. County must ensure its behavioral health workforce, including all BHSA-funded providers (contracted providers and providers employed, owned, or operated by County) are well-supported and culturally and linguistically concordant with the population to be served, and robust enough to achieve the statewide and local behavioral health goals and measures as described in W&I section 5963.02(c)(8). (BHSA Policy Manual § 9.E.)
- B. County must describe in the IP how County will conduct oversight of BHSA providers to ensure compliance with federal and state laws and regulations and requirements specified in the Policy Manual, as described in BHSA Policy Manual section 9.E.3. (W&I § 5963.02(c)(8)(I).)
- C. County must execute a contract with each non-County provider (i.e., providers that are not owned or operated by County) receiving BHSA funds that meets the requirements in BHSA Policy Manual section 9.E.1.1. County must make a good-faith effort to execute the contract before the provider begins delivering BHSA-funded services.
 - 1) If County is unable to execute a contract before the delivery of BHSA-funded services, County must execute the contract within 120 calendar days from the commencement of BHSA-funded services, consistent with the time limit for provisional SMHS provider contracts. (BHSA Policy Manual § 9.E.1.1.)
 - 2) County must codify the applicable standards outlined in this subsection 1.10.2.D of this Attachment I in each County-contracted provider contract. (BHSA Policy Manual § 9.E.2.)
- D. County must monitor each provider's compliance (including contracted providers, and providers employed, owned, or operated by County) with the following requirements as described in BHSA Policy Manual section 9.E.1.1:
 - 1) All program requirements applicable to the provider's BHSA-funded services;

- 2) Any requests for records, information, or onsite access by the county, DHCS or their designees for purposes of BHSA oversight;
 - 3) BHSA fiscal policies, as set forth in subsection 1.5 of this Attachment I and BHSA Policy Manual section 6.C;
 - 4) General standards for BHSA providers, which include ensuring providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner, as specified in W&I section 5963.02(c)(8)(C)-(F) and BHSA Policy Manual section 9.E.2; and
 - 5) County monitoring activities resulting from County's oversight of BHSA providers, as described in this subsection 1.10.2.F, below (BHSA Policy Manual § 9.E.3.)
- E. For all providers (contracted providers, and providers employed, owned, or operated by County), County must: (BHSA Policy Manual § 9.E.1.2):
- 1) Maintain records of expenditures sufficient to comply with BHOATR requirements; and
 - 2) Maintain policies and procedures to ensure compliance with the requirements described in this subsection 1.10.2.D, above.
- F. Effective July 1, 2027, County must describe how they will conduct oversight of BHSA providers in the IP, and must conduct the following monitoring activities (W&I § 5963.02(c)(8)(I); BHSA Policy Manual § 9.E.3):
- 1) Adopt a monitoring schedule for BHSA-funded providers that includes periodic site visits;
 - 2) Preserve provider monitoring records, including monitoring reports, county-approved provider CAPs, and confirmations of CAP resolutions; and
 - 3) Provide monitoring records to DHCS at any time, upon DHCS' request.

2.1 Bronzan-McCorquodale Act

2.1.1 Overview

- A. The Bronzan-McCorquodale Act realigned responsibility for administration of community mental health services, for the indigent population, to counties and provided a dedicated funding source. (Welfare and Institutions Code (W&I), § 5600.)

- B. County's primary goal in using the funds is to provide an array of treatment options to seriously emotionally disturbed children and adults who have a serious mental disorder, in every geographic area, to the extent resources are available to County. (W&I §§ 5600.3, 5600.35, 5600.4.)
- C. The mission of California's mental health system is to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings. (W&I § 5600.1.)

2.1.2 County Obligations

County must comply with all requirements in the Bronzan-McCorquodale Act (W&I § 5600 *et. seq.*), including the following:

- A. County must comply with Chapter 3 of Part 2 of Division 5 of W&I (commencing with section 5700), including that County must fund children's services pursuant to the requirements of W&I sections 5704.5 and 5704.6.
- B. County must comply with all reporting requirements pursuant to W&I sections 5610, 5664, and 5614(b)(4).
- C. To the extent resources are available, County must maintain the program principles and array of treatment options required under W&I sections 5600.2 to 5600.9, inclusive. (W&I § 5614(b)(5).)
- D. County must report data to the State required by the performance outcome systems for adults and children in accordance with W&I sections 5612 and 5613. (W&I §§ 5610, 5664, 5614(b)(6).)

2.2 Lanterman-Petris-Short Act

2.2.1 Overview

- A. The Lanterman-Petris-Short (LPS) Act was enacted to end indefinite involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism; to provide prompt evaluation and treatment, to establish consistent personal rights standards, and to provide services in the least restrictive setting for individuals served under the Act. (W&I § 5001.)
- B. Pursuant to W&I section 5400, DHCS administers the LPS Act and may adopt standards as necessary.

2.2.2 Designating Facilities for Involuntary Treatment

- A. County must comply with applicable statutes, regulations, and DHCS standards and guidance pertaining to designating and monitoring facilities to provide involuntary evaluation and treatment services under the LPS Act and the Children's Civil Commitment and Mental Health Treatment Act. (W&I §§ 5008, 5120, 5121, 5150–5349.5, 5350–5372, 5585–5599, 5651(b)(2).)

2.2.3 Reporting and Data Submission Requirements

- A. County must maintain data on the following (W&I § 5402):
- 1) The number of persons admitted for 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day post-certification intensive treatment and the conditions for which they are held, including danger to self, danger to others, grave disability due to mental health disorder, grave disability due to severe substance use disorder, grave disability due to both a mental health disorder and a severe substance use disorder;
 - 2) The number of persons transferred to mental health facilities pursuant to section 4011.6 of the Penal Code;
 - 3) The number of persons for whom temporary conservatorships are established, and the number of persons for whom conservatorships are established in the County;
 - 4) Services provided, including payer information, and clinical outcomes for the individuals identified in paragraphs (1) through (3) of this subsection 2.2.3.A, above;
 - 5) Demographic data for the individuals identified in paragraphs (1) through (3) of this subsection 2.2.3.A, above. Demographic data must include age, sex, gender identity, race, ethnicity, primary language, sexual orientation, veteran status, and housing status, to the extent those data are available;
 - 6) The number of persons admitted or detained once, between two and five times, between six and eight times, and greater than eight times for each type of admission or detention including 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day postcertification intensive treatment;
 - 7) The waiting periods for individuals prior to receiving an evaluation in a designated and approved facility pursuant to W&I sections 5150 or 5151 and waiting periods for individuals prior to receiving treatment services in a designated facility, including the reasons for waiting periods;

- 8) Number of all County-contracted beds; and
- 9) Number and outcomes for the following:
 - a. The certification review hearings (W&I § 5256);
 - b. The petitions for writs of habeas corpus filed (W&I § 5275);
 - c. The judicial review hearings held (W&I § 5276);
 - d. The petitions for capacity hearings filed (W&I § 5332); and
 - e. The capacity hearings held (W&I § 5334).
- B. County must provide data as required in this subsection 2.2.3.A, above, or other information, records, and reports, which DHCS deems necessary for the purposes of W&I section 5402 on a quarterly basis, or more frequently as required by DHCS.
- C. County must maintain data on the number of persons whose rights under W&I section 5325 were denied and the right or rights which were denied. Quarterly, County must provide DHCS with a report of this information (W&I § 5326.1.)
- D. County must collect information regarding the number of patients receiving treatment for each patient type, total treatments given, complications attributed to treatment, excessive treatment, and payment source of patients, and report this information quarterly to DHCS (W&I § 5326.15(a).)

2.3 Laura's Law

2.3.1 County Obligations

- A. County must comply with Article 9 of Part 1 of Division 5 of W&I (Laura's Law), unless its governing body has passed a resolution in compliance with W&I section 5349.
- B. County either individually or pursuant to its memorandum of understanding with a group of Counties to which County has joined for participation in Laura's Law, must:
 - 1) Maintain and provide data to DHCS regarding the services County provides under Laura's Law. (W&I § 5348.) The report must include an evaluation of the effectiveness of the strategies employed by each program in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. County must maintain and include in the report to DHCS all of the information enumerated in W&I section 5348(d).

- 2) Pay for the provision of services under W&I sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Behavioral Health Services Fund when included in County plans pursuant to W&I sections 5847 or 5963.02 and any other funds from which the Controller makes distributions to the counties for those purposes. (W&I § 5349.)

2.4 Projects For Assistance In Transition From Homelessness Program

2.4.1 Overview

- A. Pursuant to Title 42 of the United States Code (USC), sections 290cc-21 through 290cc-35, inclusive, the State of California has been awarded federal homeless funds through the federal McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant.
- B. The PATH grant funds community-based outreach, mental health and substance abuse referral/treatment, case management and other support services, as well as a limited set of housing services for the homeless mentally ill.

2.4.2 Application for Funds and Compliance with Requirements

- A. County must submit its Request for Application (RFA) responses and required documentation specified in DHCS' RFA to receive PATH funds. County must complete its RFA responses in accordance with the instructions, enclosures and attachments distributed annually from DHCS by email.
- B. If County applied for and DHCS approved its request to receive PATH grant funds, the following documents are incorporated by reference in this Contract and County must comply with all applicable provisions:
 - 1) The Notice of Funding Opportunity (NOFO) issued by Substance Abuse and Mental Health Services Administration (SAMHSA) for the PATH program;
 - 2) The State's approved application to SAMHSA for PATH funding;
 - 3) The federal Notice of Award issued to DHCS;
 - 4) DHCS's RFA;
 - 5) County's RFA responses, including the proposed scope of work and budget details.

2.4.3 Federal Authorities

The PATH grant is a federal award within the meaning of Title 2 Code of Federal Regulations (CFR) parts 200 and 300. County's receipt of PATH funds is a subaward to County. County is a subrecipient and subject to all applicable requirements in 2 CFR parts 200 and 300, including, but not limited to, the County requirement to have a single audit performed for PATH funds in accordance with the audit requirements therein.

2.5 Community Mental Health Services Block Grant

2.5.1 Overview

- A. Pursuant to Title 42 USC section 300x *et seq.*, the State of California has been awarded the federal Community Mental Health Services Block Grant funds, known as Mental Health Block Grant (MHBG).
- B. County mental health agencies utilize MHBG funding to provide a broad array of mental health services within their mental health system of care programs. These programs provide services to the following target populations: children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses.

2.6 Application for Funds and Compliance with Requirements

- A. County must submit its RFA responses and required documentation specified in DHCS' RFA to receive MHBG funding. County must complete its RFA responses in accordance with the instructions, enclosures and attachments.
- B. If County applied for and DHCS approved its request to receive MHBG grant funds, the following documents are incorporated by reference in this Contract and County must comply with all applicable provisions:
 - 1) The NOFO issued by SAMHSA for the MHBG program;
 - 2) The State's approved application to SAMHSA for MHBG funding;
 - 3) The federal Notice of Award issued to DHCS;
 - 4) DHCS's RFA;
 - 5) County's RFA responses, including the proposed scope of work and budget details.

2.6.1 Federal Authorities

- A. The MHBG grant is a federal award within the meaning of 2 CFR parts 200 and 300. County's receipt of MHBG funds is a subaward to County. County is a subrecipient and subject to all applicable

requirements in 2 CFR parts 200 and 300, and 45 CFR part 96 including, but not limited to, the County requirement to have a single audit performed for MHBG funds in accordance with the audit requirements therein.

- B. MHBG Funding must not be used to supplant existing resources. County expenditure of MHBG Funds are subject to State and federal oversight, including on-sight program performance reviews and federal audits. (42 USC § 300x-4(b); 42 CFR § 200.503.)

2.7 Substance Use Prevention, Treatment, and Recovery Services Block Grant

2.7.1 Overview

- A. Pursuant to Title 42 USC section 300x *et seq.*, the State of California has been awarded the federal Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).
- B. County Alcohol and Other Drug Programs utilize SUBG funding to provide a broad array of alcohol and other drug treatment and prevention services within their system of care programs.

2.7.2 Application for Funds and Compliance with Requirements

- A. County must submit its RFA responses and required documentation specified in DHCS' RFA to receive SUBG funding. County must complete its RFA responses in accordance with the instructions, enclosures and attachments.
- B. If County applied for, and DHCS approved its request to receive SUBG funds, the following documents are incorporated by reference in this Contract and County must comply with all applicable provisions:
 - 1) The NOFO issued by SAMHSA for the SUBG program;
 - 2) The State's approved application to SAMHSA for SUBG funding;
 - 3) The federal Notice of Award issued to DHCS;
 - 4) DHCS's RFA; and
 - 5) County's RFA responses, including the proposed scope of work and budget details.

2.7.3 Federal Authorities

- A. The SUBG is a federal award within the meaning of 2 CFR parts 200 and 300. County's receipt of SUBG funds is a subaward to County. County is a subrecipient and subject to all applicable requirements in 2 CFR parts 200 and 300, and Title 45 CFR part 96, including, but not limited to, the County

requirement to have a single audit performed for SUBG funds in accordance with the audit requirements therein.

- B. SUBG Funding must not be used to supplant existing resources. County expenditure of SUBG Funds are subject to State and federal oversight, including on-sight program performance reviews and federal audits. (45 CFR § 96.134(a), 42 CFR § 200.503.)

2.8 Crisis Counseling Assistance and Training Program

2.8.1 Overview

- A. Pursuant to Title 42 USC section 5183, and upon the issuance of a Presidential declaration of a major disaster, the State of California may be awarded Federal Emergency Management Agency (FEMA) funding for the Crisis Counseling Assistance and Training Program (CCP) pursuant to 44 CFR section 206.171.
- B. The CCP supports short-term interventions that involve assisting disaster survivors in understanding their current situation and reactions, mitigating stress, developing coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that help survivors in their recovery process. These funds are used to provide services to all individuals affected during a disaster.

2.8.2 Request for Funds and Compliance with Requirements

- A. Participation in the CCP is optional.
- B. If County participates in the CCP, it must comply with all applicable federal and State requirements, including:
 - 1) FEMA or SAMHSA approved funding application and budget;
 - 2) Applicable requirements in the Notice of Award (from FEMA or SAMHSA) to the State, including special and standard program conditions or terms, supplemental grant information, and the federal Health and Human Services Grants Policy Statement; and
 - 3) 44 CFR section 206.171, 42 CFR part 38, and FEMA or SAMHSA CCP secondary guidance.

2.8.3 Federal Authorities

- A. The CCP is a federal award within the meaning of 2 CFR part 200. County's receipt of CCP funding is a subaward to County. County is a subrecipient and subject to all applicable requirements in 2 CFR part 200 and 44 CFR section 206.207(c), including, but not limited to, the County

requirement to have a single audit performed for CCP funds in accordance with the audit requirements therein.

- B. CCP Funding must not be used to supplant existing resources. County expenditure of CCP Funds are subject to State and federal oversight, including on-sight program performance reviews and federal audits. (44 CFR § 206.171(k), 42 CFR § 38.9.)
- C. For reference, FEMA Crisis Counseling Assistance and Training Program (FEMA secondary guidance), is accessible at the following link:
<https://www.samhsa.gov/technical-assistance/dtac/ccp>.

Exhibit A, ATTACHMENT II

Table of Contents

1.0 Additional Terms and Conditions

- 1.1 Dispute Resolution Process for Projects For Assistance In Transition From Homelessness, Community Mental Health Services Block Grant, and Substance Use Prevention, Treatment, and Recovery Services Block Grant
- 1.2 Welfare and Institutions Code section 5751.7 Waiver
- 1.3 Reporting, Data Submission, and Data Sharing Requirements

1.1 Dispute Resolution Process for Projects For Assistance In Transition From Homelessness, Community Mental Health Services Block Grant, and Substance Use Prevention, Treatment, and Recovery Services Block Grant

1.1.1 Dispute Resolution Process

- A. Notwithstanding Exhibit D, if a dispute arises between County and DHCS regarding County's compliance with subsection 2.4 (Projects For Assistance In Transition From Homelessness), subsection 2.5 (Community Mental Health Services Block Grant), or subsection 2.6 (Substance Use Prevention, Treatment and Recovery Services Block Grant) of Attachment I, the County must seek resolution using the process outlined in this subsection 1.1.1.D, below.
- B. County must first informally discuss the problem with the DHCS Project Representative listed in subsection 1.1.1.D, below. If County and DHCS are unable to resolve the problem informally, County must mail a written Statement of Dispute, with supporting evidence, to DHCS at the address listed in subsection 1.1.1.D, below. The Statement of Dispute must describe the issues in dispute, the legal authority or other basis for County's position, and the remedy sought.
- C. The Branch Chief of DHCS' Federal Grants Branch will decide the dispute and mail a written decision to the County within twenty (20) working days of receiving the Statement of Dispute from County. The decision will be in writing, and include a statement of the reasons for the decision that addresses each issue raised by County. If applicable, the decision will also indicate any action County must take to comply with the decision. The Branch Chief's decision will be the final administrative determination of DHCS.
- D. Unless otherwise agreed to in writing by DHCS, the Statement of Dispute, supporting documentation, and all correspondence and documents related to the dispute resolution process must be directed to the following:

California Department of Health Care Services
Community Services Division/Federal Grants Branch
Attention: Waheeda Sabah
1501 Capitol Avenue
P.O. Box Number 997413, Mail Stop 2624
Sacramento, CA, 95899-7413

1.2 Welfare and Institutions Code section 5751.7 Waiver

1.2.1 Overview

- A. County must comply with Welfare and Institutions Code (W&I) section 5751.7 and ensure that minors are not admitted into inpatient psychiatric treatment with adults. If this requirement creates undue hardship to County due to inadequate or unavailable alternative resources, County may request a waiver of this requirement. County must submit the waiver request on Exhibit A, Attachment III of this Contract to DHCS.
- B. DHCS must review County's waiver request and provide a written notice of approval or denial of the waiver. If County's waiver request is denied, County must prohibit health facilities from admitting minors into psychiatric treatment with adults.
- C. County must submit the waiver request to DHCS at the time County submits this Contract, signed by County, to DHCS for execution. County must complete Exhibit A, Attachment III and attach it to this Contract.
- D. Execution of this Contract by DHCS will not constitute approval of a waiver submitted pursuant to this section.
- E. Any waiver granted in the prior fiscal year's Contract will be deemed to continue until either party chooses to discontinue it, as specified in Exhibit A, Attachment III. Execution of this Contract will continue independently of the waiver review and approval process.
- F. In unusual or emergency circumstances, when County needs to request waivers after this Contract has been executed, these requests should be e-mailed, with the subject line "Performance Contract: Unusual or Emergency Circumstances", immediately to the contact listed in this subsection 1.2.1.G, below.
- G. County must submit waiver requests for designated facilities by e-mail to:
 - California Department of Health Care Services
 - Licensing and Certification Division
 - Mental Health Licensing and Certification Branch
 - e-mail: LPSinfo@dhcs.ca.gov.
- H. Each admission of a minor to a facility that has an approved waiver must be reported to the Local Behavioral Health Director.

1.3 Reporting, Data Submission, and Data Sharing Requirements

1.3.1 Data Requirements

- A. County must comply with all data and information submission requirements specified in State and federal law, this Contract, and all applicable DHCS guidance. (W&I §§ 5610(a)(1), 5664(a), 5963.04(a)(2).) Applicable laws include:
- 1) Title 42 of the United States Code (USC), sections 290cc-21 through 290ee-10 and 300x through 300x-68, inclusive;
 - 2) W&I sections 5000 through 5987; and
 - 3) All corresponding regulations that implement, interpret or make specific, these federal and State laws.
- B. County must provide data and information regarding the following programs as required by, and in accordance with, federal and State laws and DHCS guidance:
- 1) The Behavioral Health Services Act (BHSA), as outlined in Exhibit A, Attachment I, Article 1.0;
 - 2) Projects for Assistance in Transition from Homelessness (PATH), as outlined in Article 2.0, subsection 2.4 of Attachment I;
 - 3) Community Mental Health Services Block Grant (MHBG), as outlined in Article 2.0, subsection 2.5 of Attachment I;
 - 4) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), as outlined in Article 2.0, subsection 2.6 of Attachment I; and
 - 5) County provision of community behavioral health services provided with 1991 and 2011 realignment funds (other than Medi-Cal).

1.3.2 Reporting Requirements

- A. County must comply with all reporting requirements as specified in DHCS guidance and State and federal law. (W&I §§ 5610(a)(1), 5664(a), 5651(b)(7), 5963.04(e)(3)(A); Health & Safety Code §§ 11754(a), 11755(q)(1).)
- B. County must submit complete and accurate information to DHCS, and as applicable to the Behavioral Health Services Oversight and Accountability Commission, including, but not limited to, the following (W&I §§ 5610(a)(1), 5963.04(a)(1)-(2)):

- 1) Client and Service Information (CSI) System Data, as specified in Title 9 of the California Code of Regulations (CCR) section 3530.10 and according to the specifications set forth in DHCS' CSI Data Dictionary. County must:
 - a. Report complete and accurate monthly CSI data to DHCS within 60 calendar days after the end of the month in which services were provided.
 - b. If complete and accurate data are not reported within 60 calendar days, County must be in compliance with an approved plan of correction.
 - c. Make diligent efforts to minimize errors on the CSI error file.
 - d. Correct all errors on the CSI error file.
 - e. Notify DHCS 90 calendar days prior to any change in reporting system or change of automated system vendor.
 - 2) Full Service Partnership Performance Outcome data (9 CCR § 3530.30)
 - 3) Consumer Perception Survey (9 CCR § 3530.40)
 - 4) Substance use disorder treatment services data in accordance with W&I section 5891.5(b).
- C. Effective January 1, 2027, County must capture and submit all behavioral health individual service-level (ISL) encounter data to DHCS pursuant to applicable DHCS guidance. (W&I §§ 5610(b), (d), 5664(a).)
- D. In the event that DHCS or County determines that, due to federal or State law changes or business requirements, an amendment is needed of either County's or DHCS' obligations under this contract relating to either DHCS' or County's information needs, both DHCS and County agree to provide notice to the other party as soon as feasible prior to implementation. This notice must include information and comments regarding the anticipated requirements and impacts of the projected changes. DHCS and County agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.
- E. County must submit complete, accurate, reasonable, and timely data as mandated by State and federal law and DHCS guidance, and in a form and manner specified by DHCS.

- F. If applicable to a specific federal or State funding source covered by this Contract, County must require each of its subcontractors to submit a fiscal year-end cost report to DHCS no later than December 31 following the close of the fiscal year, in accordance with applicable federal and State laws, regulations, and DHCS guidance.

1.3.3 Data Sharing Requirements

- A. County must comply with all data sharing requirements as mandated by and in accordance with applicable federal and State law and applicable Data Exchange Framework Policies and Procedures and DHCS guidance. (W&I §§ 14197.71(d)(1), 14184.102(j).)
- B. County must implement data sharing policies and procedures and adhere to required state and federal care coordination rules and regulations, including bidirectionally sharing the minimum necessary individual data in real time with other counties, Managed Care Plans (MCPs), County-contracted providers, and other delivery systems and partners that support service delivery, care coordination, referrals, closed loop referrals, and care transitions. (W&I § 14197.71(d)(1).)

Exhibit A, Attachment III

Request for Waiver

Request for Waiver Pursuant To Section 5751.7 of the Welfare and Institutions Code

_____ hereby requests a waiver for the following public or private health facilities pursuant to section 5751.7 of the Welfare and Institutions Code for the term of this contract. These are facilities where minors may be provided psychiatric treatment with nonspecific separate housing arrangements, treatment staff, and treatment programs designed to serve minors. However, no minor shall be admitted for psychiatric treatment into the same treatment ward as an adult receiving treatment who is in the custody of any jailor for a violent crime, is a known registered sex offender, or has a known history of, or exhibits inappropriate sexual or other violent behavior which would present a threat to the physical safety of others.

The request for waiver must include, as an attachment, the following:

1. A description of the hardship to the County/City due to inadequate or unavailable alternative resources that would be caused by compliance with the State policy regarding the provision of psychiatric treatment to minors.
2. The specific treatment protocols and administrative procedures established by the County/City for identifying and providing appropriate treatment to minors admitted with adults.
3. The specific plan and administrative procedures established by the County ensuring that a designated facility admitting both adults and minors will house them in specific and separate housing arrangements.
4. Name, address and telephone number of the facility:
 - Number of the facility's beds designated for involuntary treatment
 - Type of facility, license(s), certification(s) or accreditation(s) held (including licensing, certifying, or accrediting agency and license, certificate, or accreditation number)
 - A copy of the facility's current license, certificate or accreditation and a description of the program, including target population and age range, and genders to be admitted to the designated facility.
5. If applicable, include a copy of the County's approval letter indicating the County has designated a facility to house both minors and adults.

To rescind the waiver, either party shall send a letter to the other party on official letterhead signed by their respective County Behavioral Health Director or his or her designee indicating that the party no longer grants or requests a waiver. If not otherwise specified by the party in the letter to the respective party, the discontinuance shall be effective the date the letter to the party is postmarked and the facility shall no longer be waived as of this date. When DHCS denies or rescinds a waiver issued to a County, the facility and the County Behavioral Health Director or designee shall receive written notification from DHCS, by certified mail or e-mail. The notice shall include the decision, the basis for the decision, and any supporting documentation. DHCS' denial or rescission is the final administrative decision and there is no further review or appeal.

Exhibit B – Budget Detail Provisions

1.0 Budget Contingency Clause

- A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, this Contract will be of no further force and effect. In this event, DHCS will have no liability to pay any funds whatsoever to County or to furnish any other considerations under this Contract and County will not be obligated to perform any provisions of this Contract.
- B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS will have the option to either cancel this Contract with no liability occurring to DHCS, or offer an agreement amendment to County to reflect the reduced amount.

Exhibit D Special Terms and Conditions

The provisions herein apply to this Agreement **unless** the applicable conditions do not exist, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the provisions are removed by reference on the face of this Agreement.

The use of headings or titles throughout this exhibit is for convenience only and will not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" will also mean, "agreement", "grant", "grant agreement", "Grantee" and "Subgrantee" respectively.

The terms "California Department of Health Care Services", "California Department of Health Services", "Department of Health Care Services", "Department of Health Services", "CDHCS", "DHCS", "CDHS", and "DHS" will all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.).

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1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

- a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action will include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212). Such notices will state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and will post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 Code of Federal Regulations (C.F.R.) Part 60, "Office of the Federal Contract Compliance

Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor.

- e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 C.F.R. Part 60, “Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 C.F.R. Part 60, “Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
- g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,’ and as supplemented by regulation at 41 C.F.R. Part 60, “Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. § 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement will, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for non-represented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates will apply upon their effective date and no amendment to this Agreement will be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California will be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions will apply:

- 1) **Major equipment/property:** A tangible or intangible item having a base unit cost of **\$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.
- 2) **Minor equipment/property:** A tangible item having a base unit cost of less than \$5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. **Government and public entities (including state colleges/universities and auxiliary organizations)**, whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 will also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

- 1) Equipment/property purchases must not exceed \$50,000 annually.

To secure equipment/property above the annual maximum limit of \$50,000, the Contractor must make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS will be deducted from the funds available in this Agreement. Contractor will submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

- 2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 will also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.
- 3) Nonprofit organizations and commercial businesses must use a procurement system that meets the following standards:
 - a) Maintain a code or standard of conduct that will govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent will participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
 - b) Procurements must be conducted in a manner that provides, to the maximum extent practical, open, and free competition.
 - c) Procurements must be conducted in a manner that provides for all of the following:
 - i. Avoid purchasing unnecessary or duplicate items.
 - ii. Equipment/property solicitations must be based upon a clear and accurate description of the technical requirements of the goods to be procured.
 - iii. Take positive steps to utilize small and veteran owned businesses.
 - d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of \$5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or

desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

- e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.
- f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.
- g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) must also be maintained on file by the Contractor and/or subcontractor for inspection or audit.
- h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment / Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

- a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 will apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement will be considered state equipment and the property of DHCS.

1) Reporting of Equipment/Property Receipt

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor must report the

receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor must use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor must request a copy from the DHCS Program Contract Manager.

2) Annual Equipment/Property Inventory

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor must submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor must request a copy from the DHCS Program Contract Manager. Contractor must:

- a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).
 - b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.
 - c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.
- b. Title to State equipment and/or property will not be affected by its incorporation or attachment to any property not owned by the State.
 - c. Unless otherwise stipulated, DHCS will be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.
 - d. The Contractor and/or Subcontractor must maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.
 - 1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor must immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor must promptly submit one copy of the theft report to the DHCS Program Contract Manager.
 - e. Unless otherwise stipulated by the Program funding this Agreement, equipment

and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, must only be used for performance of this Agreement or another DHCS agreement.

- f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor must provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and must, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property will be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions will be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. Motor Vehicles

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

- 1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor must return such vehicles to DHCS and must deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.
- 2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California will be the legal owner of said motor vehicles and the Contractor will be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.
- 3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, must hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator must also hold a State of California Class B driver's license.
- 4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, must provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

- a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of \$1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.
- b) The Contractor and/or Subcontractor must, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance must identify the DHCS contract or agreement number for which the insurance applies.
- c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, will remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.
- d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.
- e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:
 - I. The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).
 - II. The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.
 - III. The insurance carrier must notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices will contain a reference to each agreement number for which the insurance was obtained.
- f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance

Management. The Contractor will be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services will be performed prior to obtaining said approval.

- g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

- a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing \$5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding \$5,000, the Contractor must obtain at least three bids or justify a sole source award.
 - 1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.
 - 2) DHCS may identify the information needed to fulfill this requirement.
 - 3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:
 - a) A local governmental entity or the federal government,
 - b) A State college or State university from any State,
 - c) A Joint Powers Authority,
 - d) An auxiliary organization of a California State University or a California community college,
 - e) A foundation organized to support the Board of Governors of the California Community Colleges,
 - f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,
 - g) Firms or individuals proposed for use and approved by DHCS' funding program via acceptance of an application or proposal for funding or pre/post contract award negotiations,
 - h) Entities and/or service types identified as exempt from advertising and competitive bidding in [State Contracting Manual Volume 1 Chapter 5 Section 5.80 Subsection B.](#)

- i) Entities whose name and budgeted costs have been submitted to DHCS in response to a competitive Invitation for Bid or Request for Proposal.
- b. Agreements with governmental or public entities and their auxiliaries, or a Joint Powers Authority
 - 1) If the total amount of all subcontracts exceeds twenty-five percent (25%) of the total agreement amount or \$50,000, whichever is less and each subcontract is not with an entity or of a service type described in paragraph a(3) herein, DHCS will:
 - a) Obtain approval from DGS to use said subcontracts, or
 - b) If applicable, obtain a certification from the prime Contractor indicating that each subcontractor was selected pursuant to a competitive bidding process requiring at least three bids from responsible bidders, or
 - c) Obtain attestation from the Secretary of the California Health and Human Services Agency attesting that the selection of the particular subcontractor(s) without competitive bidding was necessary to promote DHCS' program needs and was not done for the purpose of circumventing competitive bidding requirements.
 - 2) When the conditions of b(1) apply, each subcontract that is not with a type of entity or of a service type described in paragraph a(3) herein, must not commence work before DHCS has obtained applicable prior approval to use said subcontractor. DHCS will inform the Contractor when DHCS has obtained appropriate approval to use said subcontractors.
- c. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.
 - 1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor must take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.
 - 2) The requirements specified in Provision 28 entitled, "Use of Disabled Veteran Business Enterprises (DVBEs)" will apply to the use and substitution of DVBE subcontractors.
 - 3) The requirements specified in Provision 30 entitled, "Use of Small Business Subcontractors" will apply to the use and substitution of small business subcontractors.
- d. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of \$5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers must be confirmed in writing by DHCS.

- e. Contractor must maintain a copy of each subcontract entered into in support of this Agreement and must, upon request by DHCS, make copies available for approval, inspection, or audit.
- f. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.
- g. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.
- h. When entering into a consulting agreement with DHCS, the contract must include detailed criteria and a mandatory progress schedule for the performance of the contract, and must require Contractor to provide a detailed analysis of the costs of performing the contract.
- i. The Contractor must ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.
- j. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."
- k. Unless otherwise stipulated in writing by DHCS, the Contractor will be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.
- l. Contractor must, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 18, 19, 20, 32, 37, 38 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement must be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of \$10,000.)

- a. The Contractor and/or Subcontractor must maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.
- b. The Contractor's and/or Subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records must be subject at all reasonable times to inspection, audit, and reproduction.
- c. Contractor agrees that DHCS, DGS, the California State Auditor, or their designated representatives including, but not limited to, the Comptroller General of the United States will have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code (Gov. Code) § 8546.7, Title 2 Code of California Regulations (C.C.R.), § 1896.77 and other applicable State laws.) The Contractor must comply with the above and be aware of the penalties for violations of fraud and for obstruction of an investigation under applicable State laws.
- d. The Contractor and/or Subcontractor must preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code (Mil. & Vet. Code) § 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.
 - 1) If this Agreement is completely or partially terminated, the records relating to the work terminated must be preserved and made available for a period of three years from the date of any resulting final settlement.
 - 2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.
- e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other

data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

- f. For agreements with non-profit entities funded in part or whole with federal funds in the amount of \$750,000 or more, the Contractor must, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 et seq.
- g. For Direct Service Contracts as defined in Health & Saf. Code § 38040 in the amount of \$25,000 or more, the Contract must comply with the audit requirements set forth in Health & Saf. Code § 38040.

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor must provide and must require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations will be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

- a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.
- b. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.
- c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.
- d. DHCS has the option to invalidate or cancel the Agreement with 30-days

advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. For Cause

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State will be deducted from any sum due the Contractor under this Agreement and the balance, if any, will be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State will pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. For Convenience

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least thirty (30) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the Contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

(Applicable to all agreements that may be fund, in whole or part, the creation and development Intellectual Property.)

- a. The State will be the owner of all rights, title, and interest in any and all intellectual property or other products or materials created or developed pursuant to this Agreement, whether or not published, produced, manufactured or distributed. The copyright, patent and/or other intellectual property rights to any and all products created, provided or developed, in whole or part, under this Agreement, whether or not published, produced, manufactured or distributed belongs to the State from the moment of creation.
- b. The State retains all rights to use, reproduce, distribute, or display any products or materials created, provided, developed, or produced under this Agreement and any derivative products based on Agreement products or materials, as well as all other rights, privileges, and remedies granted or reserved to a copyright, patent, service mark or trademark owner under statutory and common law.
- c. Contractor agrees to cooperate with State and to execute any document(s) that may be necessary to give the foregoing provisions full force and effect, including but not limited to, an assignment of trademark, copyright or patent rights. Contractor, subject to reasonable availability, agrees to give testimony and take all further acts necessary to acquire, transfer, maintain, and enforce the State's intellectual property rights and interest.
- d. Contractor agrees to cooperate with the State in assuring the State's sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor must require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to the State all rights, title and interest in Intellectual Property conceived, developed, derived from, or reduced to practice by the subcontractor, Contractor or the State and which result from this Agreement or any subcontract.
- e. Contractor agrees not to incorporate into or make the works developed, dependent upon any original works of authorship or Intellectual Property Rights of third parties without first (a) obtaining State's prior written permission, and (b) granting to or obtaining for State, without additional compensation, a nonexclusive, royalty-free, paid-up, irrevocable, perpetual, world-wide license, to use, reproduce, sell, modify, publicly and privately display and distribute, for any purpose whatsoever, any such prior works.
- f. Contractor will retain title to all of its Intellectual Property to the extent such intellectual Property is in existence prior to the effective date of this Agreement. **Unless otherwise specified in the Statement of Work in contracts other than those funded, in part or whole, by federal funds (see paragraph k below)**, Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in

the Intellectual Property resulting from this Agreement. Proprietary software packages that are provided at established catalog or market prices and sold or leased to the general public will not be subject to this license provision.

- g. In the case of copyrighted materials, all materials distributed under the terms of this Agreement, and any reproductions or derivative works thereof, must include a notice of copyright in a place that can be visually perceived at the direction of the State. This notice must be placed prominently on products or materials and set apart from other matter on the page or medium where it appears. The notice "Copyright" or "©", the year in which the work was first created, and the Department of Health Care Services DHCS", or other appropriate mark as directed by DHCS, must be included on any such products or materials.
- h. Contractor represents and warrants that:
 - 1) It is free to enter into and fully perform this Agreement.
 - 2) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.
 - 3) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or the State and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any State, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.
 - 4) Neither Contractor's performance nor any part of its performance will violate the right of privacy of or constitute a libel or slander against any person or entity.
 - 5) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real property, sites, locations, property or props that may be used or shown.
 - 6) It has not granted and will not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to the State in this Agreement.
 - 7) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition,

- operation or maintenance of computer software in violation of copyright laws.
- 8) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.
- i. THE STATE MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.
 - j. INTELLECTUAL PROPERTY INDEMNITY
 - 1) Contractor must indemnify, defend and hold harmless the State and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of the State's use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or the State and which result directly or indirectly from this Agreement. This indemnity obligation will apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. The State reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against the State.
 - 2) Should any Intellectual Property licensed by the Contractor to the State under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve the State's right to use the licensed Intellectual Property in accordance with this Agreement at no expense to the State. The State will have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for the State to continue using the licensed Intellectual Property; or replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, the State will be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in

equity.

- 3) Contractor agrees that damages alone would be inadequate to compensate the State for breach of any term of this Intellectual Property attachment by Contractor. Contractor acknowledges the State would suffer irreparable harm in the event of such breach and agrees the State will be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.
- k. If this Agreement is funded in whole or part by federal funds, the State will retain all Intellectual Property rights, title, and ownership, which result directly or indirectly from the Agreement pursuant to applicable federal law including, but not limited to, 45 C.F.R. § 75.322 and 45 C.F.R. § 95.617, except as provided in 37 C.F.R. Part 401.14. However, the federal government will have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.
- l. The provisions set forth herein will survive any termination or expiration of this Agreement.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of \$100,000 must comply with the following provisions unless said agreement is exempt by law.

- a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and Environmental Protection Agency regulations.
- b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. § 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. § 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor must obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor must acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

- a. The Contractor and its employees, agents, or subcontractors must protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.
- b. The Contractor and its employees, agents, or subcontractors must not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.
- c. The Contractor and its employees, agents, or subcontractors must promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.
- d. The Contractor must not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.
- e. For purposes of this provision, identity will include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.
- f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over \$5,000 under which publications, written reports and documents are developed or produced. Gov. Code § 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement must contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds \$5,000.

16. Dispute Resolution Process

- a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance

between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

- 1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor must direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance must state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief will render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief will respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.
 - 2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor must include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal must be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee will meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee will be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal. The decision rendered by the Deputy Director or his/her designee will be the final administrative determination by the Department.
- b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code (Health & Saf. Code) § 100171.
 - c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence will be directed to the DHCS Program Contract Manager.
 - d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor will be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.
 - e. Notwithstanding any dispute, the Contractor shall diligently continue performance of the Contract (including matters subject to dispute to the maximum extent possible).

17. Subrecipient Compliance

(Applicable to agreements in which a Subrecipient receives federal funding. This does not apply to Medi-Cal programs.)

Per 2 C.F.R. § 200.93, a Subrecipient is a non-federal entity that receives a subaward from a pass-through entity to carry out part of a federal award. Subrecipients must comply with certain requirements, including without limitation, audit requirements, as set forth in 2 C.F.R. Part 200, as applicable to Subrecipients. Subrecipients may be subject to applicable monitoring activities by DHCS as required in 2 C.F.R. § 200.332.

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. § 263a (CLIA) and the regulations thereunder.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

- a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 C.F.R. Part 180, 2 C.F.R. Part 376.
- b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:
 - 1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
 - 2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) violation of Federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;
 - 3) Are not presently indicted for or otherwise criminally or civilly charged by a

- governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and
- 4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.
 - 5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 C.F.R. Part 180, Subpart C as supplemented by 2 C.F.R. Part 376.
 - 6) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - 7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor must submit an explanation to the DHCS Program Contract Manager.
 - d. The terms and definitions herein have the meanings set out in 2 C.F.R. Part 180 as supplemented by 2 C.F.R. Part 376.
 - e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

- a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

- b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.
- c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.
- d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

21. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

- a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace.
- b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.
- c. Employees must notify their employer of any conviction of a criminal drug statute no later than five days after such conviction.
- d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.
- e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

22. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS

will have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

23. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or \$3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

24. Progress Reports or Meetings

(Applicable to consultant service agreements and, at DHCS' option, other agreements.)

- a. Contractor shall submit progress reports or attend meetings with state personnel at intervals determined by DHCS to determine if the Contractor is on the right track, whether the project is on schedule, provide communication of interim findings, and afford occasions for airing difficulties or special problems encountered so that remedies can be developed quickly.
- b. At the conclusion of this Agreement and if applicable, Contractor shall hold a final meeting at which Contractor shall present any findings, conclusions, and recommendations. If required by this Agreement, Contractor shall submit a comprehensive final report.

25. Performance Evaluation

- a. For all consultant service agreements of \$5000 or more:
 - 1) The Contractor's performance under this Agreement will be evaluated at the conclusion of the term of this Agreement. The evaluation will include, but not be limited to:
 - a) Whether the contracted work or services were completed as specified in the Agreement and reasons for and amount of any cost overruns.
 - b) Whether the contracted work or services met the quality standards specified in the Agreement.
 - c) Whether the Contractor fulfilled all requirements of the Agreement and if not, in what ways the Contractor did not fulfill the contract.
 - d) Factors outside the control of the Contractor, which caused difficulties in Contractor performance. Factors outside the control of the Contractor will not include a Subcontractor's poor performance.
 - e) Other information the awarding agency may require.

- f) How the Contract results and findings will be utilized to meet the agency goals.
- 2) The evaluation of the Contractor will not be a public record.

b. For all other agreements except grant agreements:

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation will not be a public record and will remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature will be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision will not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

28. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over \$10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

- a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.
- b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.
- c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Mil. & Vet. Code § 999 et seq. in that should award of this Contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Mil. & Vet. Code § 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the DGS prior to the commencement of any work by the proposed subcontractor. Changes to the

scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

- d. Requests for DVBE subcontractor substitution must include:
- 1) A written explanation of the reason for the DVBE substitution.
 - 2) A written description of the business enterprise that will be substituted, including its DVBE certification status and contact information.
 - 3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.
 - 4) One or more of the permissible justifications for substituting a DVBE subcontractor as found in 2 C.C.R. § 1896.73(g).
- e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Mil. & Vet. Code § 999.9 and other applicable State laws.
- f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), all of the following:
- 1) The total amount the prime Contractor received under the Agreement;
 - 2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;
 - 3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;
 - 4) That all payments under the Contract have been made to the DVBE(s); and
 - 5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.
- g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, the Department will withhold \$10,000 from the final payment, or the full payment if less than \$10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct \$10,000 from the final payment, or the full payment if less than \$10,000. (Mil. & Vet. Code § 999.7.)

- h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)
- i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in § 999 of the Mil. & Vet. Code, including, but not limited to, the requirements of § 999.5(d).

29. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts must be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors must take all of the following steps to further this goal.

- a. Ensure that small businesses, minority-owned firms and women's business enterprises are used to the fullest extent practicable.
- b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms and women's business enterprises.
- c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.
- d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.
- e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

30. Use of Small Business Subcontractors

(Only applicable to agreements awarded in part due to the granting of small business preference where the Contractor committed to use small business subcontractors for at least 25% of the initial contract cost or amount bid.)

- a. All Small Business Preference Request attachments and Small Business Subcontractor/Supplier Acknowledgment attachments, however labeled, completed as a condition of bidding, are incorporated herein, and made a part of this Agreement by this reference.
- b. Contractor agrees to use each small business subcontractor/supplier, as

identified in previously submitted Small Business Preference Request attachments, unless the Contractor submits a written request for substitution of a like or alternate subcontractor. All requests for substitution must be approved by DHCS, in writing (including email or fax), prior to using a proposed substitute subcontractor.

- c. Requests for substitution must be approved by the funding program and must include, at a minimum:
 - 1) An explanation of the reason for the substitution.
 - 2) A written description of the business enterprise that will be substituted, including its small business certification status and contact information.
 - 3) If substitution of an alternate small business does not occur, include a written justification and description of the steps taken to try to acquire a new small business and how that portion of the Contract will be fulfilled.
 - 4) A written description of the work to be performed by the substituted subcontractor identified by both task (if applicable) and dollar amount or percentage of the overall Contract that the substituted subcontractor will perform. The substituted business, if approved, must perform a commercially useful function in the Contract pursuant to 2 C.C.R. § 1896.15.
- d. DHCS may consent to the substitution if allowed by applicable State laws.
- e. Prior to the approval of the prime contractor's request for the substitution, the funding program will give notice in writing to the listed subcontractor of the prime contractor's request to substitute and the reasons for the request to substitute. The notice will be served by certified or registered mail to the last known address of the subcontractor. The listed subcontractor that has been so notified will have five (5) working days after the receipt of the notice to submit written objections to the substitution to the funding program. Failure to file these written objections will constitute the listed subcontractor's consent to the substitution. If written objections are filed, DHCS will give notice in writing of at least five (5) working days to the listed subcontractor of a hearing by DHCS on the prime contractor's request for substitution.
- f. Failure of the Contractor to subcontract with the small businesses listed in its bid or proposal to DHCS, or failure to follow applicable substitution rules and regulations will be grounds for DGS to impose sanctions pursuant to Gov. Code § 14842.5 and 2 C.C.R. § 1896.92. In the event such sanctions are to be imposed, the Contractor be notified in writing and entitled to a hearing pursuant to Gov. Code § 14842. and 2 C.C.R. § 1896.18 and § 1896.20.
- g. If requested by DHCS, Contractor agrees to provide documentation/verification, in a form agreed to by DHCS, that small business subcontractor usage under this Agreement complies with the commitments specified during the contractor selection process.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering into federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. § 1601, et seq.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Gov. Code §§ 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

- a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.
- b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.
- c. Grantee must, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.
- d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee must provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with § 100525) of Chapter 3 of Part 1 of Division 101 of the Health & Saf. Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

- a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.
- b. As used herein, fringe benefits do not include:
 - 1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
 - 2) Director's and executive committee member's fees.

- 3) Incentive awards and/or bonus incentive pay.
 - 4) Allowances for off-site pay.
 - 5) Location allowances.
 - 6) Hardship pay.
 - 7) Cost-of-living differentials.
- c. Specific allowable fringe benefits include:
- 1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.
- d. To be an allowable fringe benefit, the cost must meet the following criteria:
- 1) Be necessary and reasonable for the performance of the Agreement.
 - 2) Be determined in accordance with generally accepted accounting principles.
 - 3) Be consistent with policies that apply uniformly to all activities of the Contractor.
- e. Contractor agrees that all fringe benefits must be at actual cost.
- f. Earned/Accrued Compensation
- 1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.
 - 2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.
 - 3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

34. Suspension or Stop Work Notification

- a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.
- b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification will remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.
 - 1) Upon receipt of a suspension or stop work notification, the Contractor must immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.
 - 2) Within 90 days of the issuance of a suspension or stop work notification, DHCS will either:

- a) Cancel, extend, or modify the suspension or stop work notification; or
- b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.
- c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.
- d. If the suspension or stop work notification is canceled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification will require an amendment to the Agreement.
- e. If a suspension or stop work notification is not canceled and the Agreement is canceled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS will allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.
- f. DHCS will not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications must follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

- a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Legal Services Contract Requirements

(Applicable only to agreements involving the performance of legal services.)

The Contractor must:

- a. Adhere to legal cost and billing guidelines designated by DHCS.
- b. Adhere to litigation plans designated by DHCS.
- c. Adhere to case phasing of activities designated by DHCS.
- d. Submit and adhere to legal budgets as designated by DHCS.
- e. Maintain legal malpractice insurance in an amount not less than the amount designated by DHCS. Said amount must be indicated in a separate letter to the Contractor.

- f. Submit to legal bill audits and law firm audits if requested by DHCS. Such audits may be conducted by State employees or its designees or by any legal cost control providers retained by DHCS for such purpose.
- g. Applicable only to legal agreements of \$50,000 or more:

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

37. Compliance with Statutes and Regulations

- a. The Contractor must comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement. This includes any changes to the applicable laws, regulations, and/or published guidelines that arise after the execution of this Agreement.
- b. For federally funded agreements, these authorities include, but are not limited to, 2 C.F.R. Part 200, subpart F, Appendix II; 42 C.F.R. Part 431, subpart F; 42 C.F.R. Part 433, subpart D; 42 C.F.R. Part 434; 45 C.F.R. Part 75, subpart D; and 45 C.F.R. Part 95, subpart F. To the extent applicable under federal law, this Agreement will incorporate the contractual provisions in these federal regulations and they will supersede any conflicting provisions in this Agreement.

38. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of \$100,000 per Section 1352 of the 31, U.S.C.)

- a. Certification and Disclosure Requirements
 - 1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds \$100,000 at any tier, must file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.
 - 2) Each recipient must file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that

- contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.
- 3) Each recipient must file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:
 - a) A cumulative increase of \$25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;
 - b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or
 - c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.
 - 4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding \$100,000 at any tier under a contract or agreement, or grant must file a certification, and a disclosure form, if required, to the next tier above.
 - 5) All disclosure forms (but not certifications) must be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person must forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
CERTIFICATION REGARDING LOBBYING

The recipient certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned must complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" (Attachment 2) in accordance with its instructions.
3. The recipient must require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of \$100,000 or more, and that all subrecipients must certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification will be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

By signing or otherwise accepting the Agreement, the recipient certifies and files this Attachment 1. **CERTIFICATION REGARDING LOBBYING**, as required by Section 1352, Title 31, U.S.C., unless the conditions stated in paragraph 2 above exist. In such case, the awardee/contractor must complete and sign Attachment 2. **CERTIFICATION REGARDING LOBBYING and returning it to the Department of Health Care Services.**

**Attachment 2
CERTIFICATION REGARDING LOBBYING**

Approved by OMB (0348-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:		2. Status of Federal Action:		3. Report Type:	
_ a. contract _ b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance		_ a. bid/offer/application b. initial award c. post-award		_ a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.	
4. Name and Address of Reporting Entity:			5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:		
<input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier ____, if known:					
Congressional District, If known:			Congressional District, If known:		
6. Federal Department/Agency			7. Federal Program Name/Description:		
			CDFA Number, if applicable: _____		
8. Federal Action Number, if known:			9. Award Amount, if known:		
10.a. Name and Address of Lobbying Registrant (If individual, last name, first name, MI):			b. Individuals Performing Services (including address if different from 10a. (Last name, First name, MI):		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than \$100,000 for each such failure.					
Signature:					
Print Name:					
Title:					
Telephone Number:					
Date:					
Federal Use Only			Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)		

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grant.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E
Additional Provisions

1. Amendment Process

- A. This provision is in addition to provision 2 of Exhibit C, General Terms and Conditions (GTC 02/2025).
- B. Should either party, during the term of this Agreement, desire a change or amendment to the terms of this Agreement, such changes or amendments must be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes must be made through the State's official agreement amendment process, unless otherwise stipulated within this Agreement. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), the Centers for Medicare and Medicaid (CMS), or any other applicable regulatory agencies, if such approval(s) are required.

2. Termination for Convenience

- A. This provision replaces and supersedes only Provision 10(b) Termination for Convenience in Exhibit D. **Note:** Provision 10(a) Termination for Cause in Exhibit D remains in force as is.
- B. This agreement may be terminated, in whole or in part, without cause, and without penalty, by either party by giving thirty (30) calendar days advance written notice to the other party. Such notification must state the effective date of termination or cancellation and include any final performance and/or payment/invoicing instructions/requirements. Upon receipt of a notice of termination or cancellation from DHCS, Contractor must take immediate steps to stop performance and to cancel or reduce subsequent contract costs.
- C. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the Contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims.

Exhibit E
Additional Provisions

D. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

3. Insurance Requirements

Contractor must comply with the following insurance requirements:

A. General Provisions Applying to All Policies

1. Coverage Term

Coverage needs to be in force for the complete term of the contract. If insurance expires during the term of the contract, a new certificate must be received by the State at least thirty (30) days prior to the expiration of this insurance. Any new insurance must still comply to the original terms of the contract.

2. Policy Cancellation or Termination & Notice of Non-Renewal

Contractor is responsible to notify the State within thirty (30) days of any cancellation, non-renewal or material change that affects required insurance coverage. In the event Contractor fails to keep in effect at all times the specified insurance coverage, the State may, in addition to any other remedies it may have, terminate this Contract upon the occurrence of such event, subject to the provisions of this Contract.

3. Deductible & Other Costs

Contractor is responsible for any deductible or self-insured retention contained within their insurance program, or any premiums or assessments.

4. Primary Clause

Any required insurance contained in this contract must be primary, and not excess or contributory, to any other insurance carried by the State.

5. Insurance Carrier Required Rating

All insurance companies must carry an A rating or better. If the Contractor is self-insured for a portion or all of its insurance, review of financial information including a letter of credit may be required.

Exhibit E
Additional Provisions

6. Endorsements

Any required endorsements requested by the State must be physically attached to all requested certificates of insurance and not substituted by referring to such coverage on the certificate of insurance.

7. Inadequate Insurance

Inadequate or lack of insurance does not negate the Contractor's obligations under the contract.

8. Subcontractors

If Contractor has identified subcontractors for the work/services identified in the scope of work, the Contractor must include all subcontractors as insureds under Contractor's insurance or supply evidence of subcontractor's insurance to the State equal to policies, coverages and limits required of Contractor.

9. Certificate of Insurance

The Contractor shall furnish a Certificate of Insurance for in complete compliance with the terms of the applicable insurance requirements in this provision (i.e., coverage type; dollar limit per occurrence; cancellation requires notification to DHCS at least thirty (30) days in advance; and the State of California, its officers, agents, and employees are included as additional insureds with respect to work performed for the State of California under this Agreement).

B. Commercial General Liability

Contractor and any subcontractors must maintain general liability on an occurrence form with limits not less than \$1,000,000 per occurrence for bodily injury and property damage liability combined. If Commercial General Liability insurance or other form with a general aggregate limit is used, either the general aggregate limits must apply separately to this project/location, or the general aggregate limit must be twice the required occurrence limit. If the aggregate applies "per project/location" it must so state on the certificate. The policy must include coverage for liabilities arising out of premises, operations, independent contractors, products, completed operations, personal & advertising injury, and liability assumed under an insured contract. This insurance must apply separately to each insured against whom claim is made or suit is brought subject to the Contractor's limit of liability. The policy must be endorsed to include the State of California, its officers, agents and employees as additional insured with respect to work performed under the

Exhibit E
Additional Provisions

contract. The additional insured endorsement must be provided with the certificate of insurance.

C. Automobile Liability

Contractor must maintain motor vehicle liability with limits not less than \$1,000,000 combined single limit per accident. Such insurance must cover liability arising out of a motor vehicle including owned, hired and non-owned motor vehicles. The policy must be endorsed to include the State of California, its officers, agents and employees as additional insured with respect to work performed under the contract. The additional insured endorsement must be provided with the certificate of insurance.

D. Workers Compensation and Employers Liability

Contractor must maintain statutory worker's compensation and employer's liability coverage for all its employees who will be engaged in the performance of the Contract. Employer's liability limits of \$1,000,000 are required. The Workers' Compensation policy must be endorsed with a waiver of subrogation in favor of the State.

E. Errors and Omissions/Professional Liability

Contractor shall maintain Errors and Omissions/Profession liability with limits of not less than \$1,000,000 each incident and \$2,000,000 aggregate covering damages caused by negligent, acts or omissions. The policy retro date must be shown on a certificate of insurance and must be before the Contract date, or before the date contract work begins. Insurance must be maintained, and evidence of insurance must be provided for at least five (5) years after completion of the contract of work. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to the contract effective date, the Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after the completion of work.

Contractor must maintain Pollution Liability covering the Contractor's liability for bodily injury, property damage, and environmental damage resulting from pollution and related cleanup costs incurred, all arising out of the work or services to be performed under this agreement. Coverage must be provided for both work performed on site and during transportation as well as proper disposal of hazardous materials. Proof of Pollution during transportation must be provided on an MCS-90 form. Limits of not less than \$1,000,000 per incident, and annual aggregate amount of \$2,000,000 must be provided. The policy must name The State of California, its officers, agents, and employees as additional insured, but only with respect to work performed under the

Exhibit E
Additional Provisions

agreement.

F. Cyber Liability

Contractor shall maintain Cyber Liability insurance with limits of not less than \$2,000,000 for each occurrence and an annual aggregate of \$4,000,000 covering claims involving privacy violations, information theft, damage or destruction of electronic information, intentional and/or unintentional release of State and or private information, alteration of electronic information, extortion and network security. The policy must name The State of California, its officers, agents, and employees as additional insured with respect to work performed under the contract.

Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)
2. The term "Agreement" as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.
3. For purposes of this Agreement, the term "Business Associate" shall have the same meaning as set forth in 45 CFR section 160.103.
4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.
 - 4.1 As used in this Agreement and unless otherwise stated, the term "PHI" refers to and includes both "PHI" as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.
 - 4.2 As used in this Agreement, the term "confidential information" refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.
5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."
6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.
7. **Permitted Uses and Disclosures of PHI by Business Associate.** Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.
 - 7.1 **Specific Use and Disclosure Provisions.** Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.
 - 7.2 **Nondisclosure.** Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

8. Compliance with Other Applicable Law

- 8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:
- 8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and
- 8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 19. of this Agreement.
- 8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.
- 8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Safeguards and Security.

- 9.1.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.
- 9.1.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at <https://csrc.nist.gov/publications/detail/sp/800-53/rev-5/final>; updates will be available online at <https://csrc.nist.gov/publications/sp800>.
- 9.1.3 Business Associate shall employ FIPS 140-3 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-3 validation can be determined online at <https://csrc.nist.gov/projects/cryptographic-module-validation-program/validated-modules/search>. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.
- 9.1.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.
- 9.1.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

- 9.1.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.
- 9.1.7 Remote access to PHI from outside the continental United States, inclusive of remote access to PHI by Business Associate's support staff in identified support centers, is prohibited.
- 9.1.8 Business Associate shall only store PHI in a data center physically located within the continental United States.

9.2 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. Mitigation of Harmful Effects. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. Access to PHI. Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. Amendment of PHI. Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. Accounting for Disclosures. Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. Collaboration. The parties shall collaborate as appropriate and necessary to ensure compliance with this Agreement, including but not limited to Sections 11 – 13 of this Agreement. The parties acknowledge and agree that neither party intends that this Agreement shall create obligations and/or liabilities that do not otherwise exist as appropriate based on the nature of the work performed and applicable law.

15. Compliance with DHCS Obligations. To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

16. Access to Practices, Books and Records. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

17. Return or Destroy PHI on Termination; Survival. At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

18. Special Provision for SSA Data. If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

19. Breaches and Security Incidents. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

19.1 Notice to DHCS.

19.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification shall be provided via the DHCS Incident Reporting Portal upon discovery of the breach. If Business Associate is unable to provide notification via the DHCS Incident Reporting Portal, then Business Associate shall provide notice by email or telephone to DHCS.

19.1.2 Business Associate shall notify DHCS **within 24** hours via the online DHCS Incident Reporting Portal (or by email or telephone if Business Associate is unable to use the DHCS Incident Reporting Portal) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

19.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

19.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

19.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

19.1.2.4 Potential loss of confidential information affecting this Agreement.

19.1.3 Notice submitted to the DHCS Incident Reporting Portal will be sent to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office. If providing notice to DHCS via email, use the DHCS contact information at Section 19.6 below (collectively, "DHCS Contacts").

Notice shall be made using the DHCS Incident Reporting Portal via the link on the DHCS Data Privacy Website online at

<https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx>

Notice via email shall be made using the current DHCS "Privacy Incident Reporting Form" and shall include all information known at the time the incident is reported. The form is available online at

<https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf>

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

19.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

19.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

19.2 Investigation. Business Associate shall immediately investigate such security incident or breach.

19.3 Complete Report. Business Associate shall provide a complete report of the investigation to DHCS within ten (10) working days of the discovery of the security incident or breach. This complete report must include any applicable additional information not included in the initial submission. The complete report shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests additional information, Business Associate shall make reasonable efforts to provide DHCS with such information. DHCS will review and approve or disapprove Business Associate’s determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate’s corrective action plan.

19.3.1 If Business Associate does not submit a complete report within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the complete report.

19.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

19.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

19.6 DHCS Contact Information. To contact the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Data Privacy Unit Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office Department of Health Care Services P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

20. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

21. Audits, Inspection and Enforcement

21.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how

DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

21.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

22. Termination

22.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

22.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

22.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

22.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

23. Miscellaneous Provisions

23.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

23.2. Amendment.

23.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

23.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 23.2.1 shall constitute a material violation of this Agreement.

23.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

23.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

23.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

23.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Contractor Certification Clauses

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
County of Los Angeles	95-6000927

By (Authorized Signature)

Printed Name and Title of Person Signing

Date Executed	Executed in the County of
---------------	---------------------------

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

- 1) the dangers of drug abuse in the workplace;
- 2) the person's or organization's policy of maintaining a drug-free workplace;
- 3) any available counseling, rehabilitation and employee assistance programs; and,
- 4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

- 1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES \$50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably

required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

**BOARD LETTER/MEMO
CLUSTER FACT SHEET**

Board Letter

Board Memo

Other

CLUSTER AGENDA REVIEW DATE	5/13/2026	
BOARD MEETING DATE	6/9/2026	
SUPERVISORIAL DISTRICT AFFECTED	<input checked="" type="checkbox"/> All <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th	
DEPARTMENT(S)	Public Health	
SUBJECT	Authorization to accept and implement a forthcoming award and future awards and/or amendments from the California Department of Public Health (CDPH) to support the Childhood Lead Poisoning Prevention Program (CLPPP).	
PROGRAM	Maternal, Child, and Adolescent Health Division	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
SOLE SOURCE CONTRACT	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	If Yes, please explain why:	
SB 1439 SUPPLEMENTAL DECLARATION FORM REVIEW COMPLETED BY EXEC OFFICE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Not Applicable	
	If unsure whether a matter is subject to the Levine Act, email your packet to EOLevineAct@bos.lacounty.gov to avoid delays in scheduling your Board Letter.	
DEADLINES/ TIME CONSTRAINTS	A forthcoming award for CLPPP in the form of a Subvention Local Assistance Agreement (SLAA) is anticipated for the period of July 1, 2026, through June 30, 2028. Once received, the SLAA must be fully executed by June 30, 2028.	
COST & FUNDING	Total cost: Estimated amount of \$17,455,305	Funding source: Awarded by CPDH, partially comprised of federal Title XIX – Medical Assistance Program, Assistance Listing Number 93.778
	TERMS (if applicable): July 1, 2026, through June 30, 2028, with anticipated funding for subsequent fiscal years (FYs).	
	Explanation: Funding amounts are subject to CDPH approval and funding availability.	
PURPOSE OF REQUEST	Delegate authority to accept and implement awards and/or amendments from CDPH to support CLPPP.	
BACKGROUND (include internal/external issues that may exist including any related motions)	<p>CDPH funds support CLPPP services which include primary prevention activities, surveillance, and case management services, including environmental investigations of lead poisoning of children, that help reduce the incidence of exposure to lead and improve the consequences of exposure to children residing in Los Angeles County.</p> <p>Since 1994, Public Health has received funding from CDPH to support Public Health's CLPPP. On January 21, 2026, Public Health received a notification from the CDPH Childhood Lead Poisoning Prevention Branch Program of Public Health's CLPPP funding allocation for FYs 2026-28 and a request that Public Health submit an application for this funding. The notification also announced the State's intent to issue awards in the form of a SLAA that differs from the previous Standard Agreements. On February 13, 2026, Public Health submitted an application to CDPH for the revised program funding amount. Final funding amount is subject to approval.</p>	

EQUITY INDEX OR LENS WAS UTILIZED	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain how: As part of CLPPP preventive services, Public Health collaborates with cities with high incidence of lead poisoned children, community-based organizations, and other health organizations to ensure a high level of lead-poisoning awareness in their communities
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state which one(s) and explain how: Board Priority #1 Child Protection and Board Priority #5 Environmental Justice and Climate Health – CLPPP works to improve the health of children who live, learn, and play in Los Angeles County by preventing lead poisoning and providing complete support to lead burdened children and their families. The goal of CLPPP prevention activities is to provide education on lead poisoning prevention, lead safe work practices during the remodeling and/or repairing of homes, updated lead awareness information, and legal responsibilities of medical providers to screen children for lead poisoning.
DEPARTMENTAL CONTACTS	Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871 jbobrowsky@ph.lacounty.gov Melissa Franklin, Director, MCAH, (323) 314-8150 mfranklin@ph.lacounty.gov Craig L. Kirkwood, Jr., Deputy County Counsel, (213) 974-1751 CKirkwood@counsel.lacounty.gov

DRAFT



BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

ANISH P. MAHAJAN, M.D., M.S., M.P.H.
Chief Deputy Director

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www.publichealth.lacounty.gov



BOARD OF SUPERVISORS

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Lindsey P. Horvath
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

June 9, 2026

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**AUTHORIZATION TO ACCEPT AND IMPLEMENT A FORTHCOMING AWARD AND
FUTURE AWARDS AND/OR AMENDMENTS FROM THE CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH TO SUPPORT THE CHILDHOOD LEAD
POISONING PREVENTION PROGRAM
(ALL SUPERVISORIAL DISTRICTS) (3 VOTES)**

SUBJECT

Provide authorization to accept and implement a forthcoming award and delegated authority to accept future awards and/or amendments from the California Department of Public Health to support the Childhood Lead Poisoning Prevention Program.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Director of the Department of Public Health (Public Health), or designee, to accept and implement a forthcoming award in the form of a Subvention Local Assistance Agreement (SLAA) from the California Department of Public Health (CDPH), partially comprised of federal Title XIX – Medical Assistance Program (Title XIX) funds, Assistance Listing Number 93.778, to support the Childhood Lead Poisoning Prevention Program (CLPPP), for the period of

July 1, 2026, through June 30, 2028, at an estimated amount of \$17,455,305, as determined by CDPH, subject to review and approval by County Counsel, review by the Chief Executive Office (CEO), as needed, and notification to your Board and the CEO. The award includes provisions requiring the County to indemnify the State against all claims and losses related to this agreement and to waive all claims and recourse against the State related to this program.

2. Delegate authority to the Director of Public Health, or designee, to accept future funding to support CLPPP, that may be issued as new or supplemental awards at amounts to be determined by CDPH, subject to review and approval by County Counsel, review by CEO, as needed, and notification to your Board and the CEO.
3. Delegate authority to the Director of Public Health, or designee, to accept future amendments that are consistent with the requirements of the CDPH award referenced in Recommendation 1 and 2 that extend the funding period at amounts to be determined by CDPH; allow for a no-cost extension; and/or provide an increase or decrease in funding, subject to review and approval by County Counsel, and notification to your Board and the CEO.
4. Delegate authority to the Director of Public Health, or designee, to accept future amendments that are consistent with the requirements of the awards referenced above that reflect non-material and/or ministerial revisions to the award's terms and conditions and allow for the rollover of unspent funds and/or redirection of funds, subject to review and approval by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of Recommendation 1 will allow Public Health to accept a forthcoming award from CDPH for continued funding support of CLPPP. CLPPP includes primary prevention activities, surveillance, and case management services, including environmental investigations, to reduce the incidence of childhood lead poisoning by identifying and caring for children who are lead poisoned and preventing environmental lead exposures to children residing in Los Angeles County (LAC).

Primary prevention activities include outreach and education to medical providers, schools, parents, childcare providers, remodeling and repair contractors, hardware stores, and homeowners. The goal of these prevention activities is to provide education regarding: 1) lead poisoning prevention; 2) lead safe work practices during the remodeling and/or repairing of homes; and 3) update lead awareness information and legal responsibilities of medical providers to screen children for lead poisoning. Public Health will collaborate with cities with high incidence of lead poisoned children, community-based organizations, and other health organizations to ensure a high level of lead-poisoning awareness in their communities.

Each Supervisor

June 9, 2026

Page 3

Comprehensive case management services for lead burdened children include home visits and telehealth by public health nurses to assess the child's health and environment, coordination with medical providers, and investigation of the child's environment by registered environmental health specialists to identify potential lead hazards.

Public Health maintains a CDPH surveillance system that includes data collected from home visits and environmental investigations conducted by Public Health.

Approval of Recommendation 2 will allow Public Health to accept funding for CLPPP that may be issued as new or supplemental awards.

Approval of Recommendation 3 will allow Public Health to accept future amendments that are consistent with the requirements of the awards referenced above to extend the term at amounts to be determined by CDPH; allow for a no-cost extension; and/or provide an increase or decrease in funding. This authority is being requested to enhance Public Health's efforts to expeditiously maximize grant revenue, consistent with Board Policy 4.070: Full Utilization of Grant Funds.

Approval of Recommendation 4 will allow Public Health to accept amendments that are consistent with the requirements of the awards referenced above that reflect non-material and/or ministerial revisions to the award's terms and conditions, roll over of unspent funds, and/or redirection of funds.

Implementation of Strategic Plan Goals

The recommended actions support North Star 1: Make Investments That Transform Lives, Area Goal A - Healthy Individuals and Families; and North Star 2: Foster Vibrant and Resilient Communities, Area Goal A - Public Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Public Health will accept a forthcoming award from CDPH, at an estimated amount of \$17,455,305, for the period of July 1, 2026, through June 30, 2028. Final funding will be determined by CDPH. These funds will support staff salaries, employee benefits, operating expenses, and indirect costs.

Funding is included in Public Health's Budget for fiscal year (FY) 2026-27 and will be included in future FYs, as necessary.

There is no net County cost associated with this action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Since 1994, Public Health has received funding from CDPH to support Public Health's CLPPP.

On January 21, 2026, Public Health received a notification from the CDPH Childhood Lead Poisoning Prevention Branch Program of Public Health's CLPPP funding allocation for FYs 2026-28 and a request that Public Health submit an application for this funding. The notification also announced the State's intent to issue awards in the form of a Subvention Local Assistance Agreement (SLAA) that differs from the previous Standard Agreements. The new SLAA intends to reduce administrative burden, align programmatic outcomes with available resources, and improve lead screening and timely case management efforts.

On February 13, 2026, Public Health submitted an application to CDPH for the program funding amount. Final funding amount is subject to approval by CDPH.

IMPACT ON CURRENT SERVICES

Approval of the recommended actions will allow Public Health to accept a forthcoming award and future awards and/or amendments from CDPH to continue to support CLPPP activities to help reduce the incidence of childhood lead poisoning in children residing in LAC.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:mk
#08627

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors