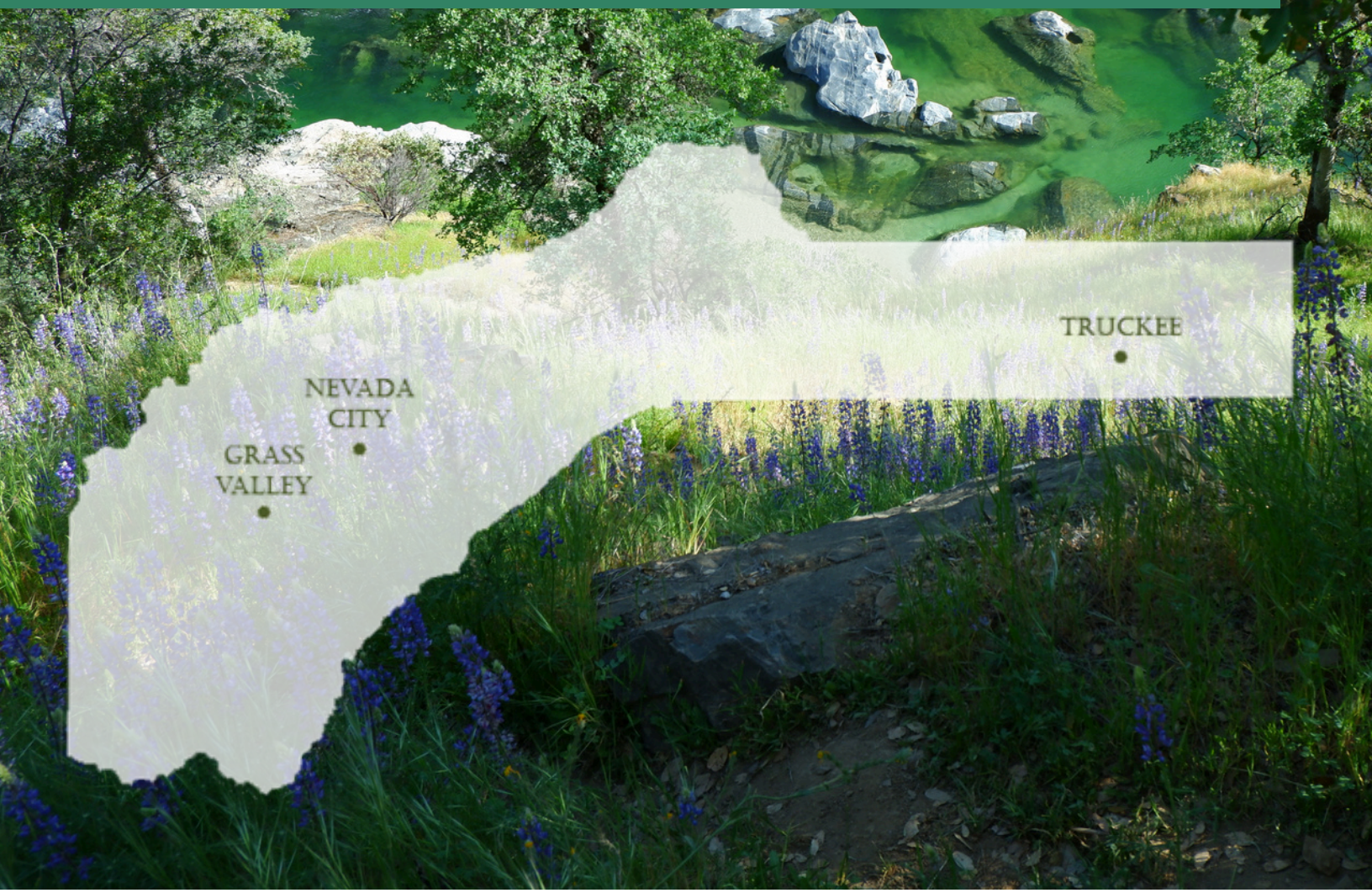
NEVADA COUNTY
BHSA INTEGRATED PLAN
FISCAL YEARS 26/27 - 28/29



NEVADA COUNTY
CALIFORNIA

BEHAVIORAL HEALTH SERVICES ACT (BHSA)
THREE YEAR INTEGRATED PLAN FOR FISCAL YEARS 2026/2027 THROUGH 2028/2029

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2026 - 2029 Integrated Plan

Nevada County

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

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Nevada County

Behavioral Health Agency Name
Nevada County Behavioral Health

Behavioral Health Agency Mailing Address
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Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

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Behavioral Health Services Act (BHSA) Coordinator

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Quality Assurance or Quality Improvement (QA/QI) lead

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County Behavioral Health System Overview

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	886
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	17
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	33
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	24

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	16
Were chronically homeless or experiencing homelessness or at risk of homelessness	<11*
Were in the juvenile justice system	<11*
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	12
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	0

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	58

Adults and Older Adults

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

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	465
Received Medi-Cal SMHS	1675
Received DMC or DMC-ODS services	849
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	330
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	102

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	219
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	68
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	22
Were in the justice system (on parole or probation and not currently incarcerated)	330
Were incarcerated (including state prison and jail)	268
Reentered the community from state prison or county jail	242
Received acute psychiatric services	190

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

Admitted or detained for 72-hour evaluation and treatment rate

680

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

Admitted for 180-day post certification intensive treatment
0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
<11*

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

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
No

Please describe the local data used during the planning process
Number of hospitalizations and length of stay over the past 3 fiscal years, crisis/mobile crisis, and CSU data for FY 24/25

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

Local CARE Act Implementation

Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.
1. As part of the CARE Court assessment and service plan, eligibility to Full Service Partnership programing is determined and connection made, as appropriate. If a CARE Court participant is engaged with an FSP provider, the county behavioral health forensic team continues to support the CARE participant through the duration of the care plan, ensuring continuity of services and care as well as attending court hearings for status updates. The BHSA funded homeless outreach team receives education on available alternative court programs, including CARE Court, and makes referrals when indicated. The homeless outreach team engages in multi-disciplinary case conferencing with the forensic team, local law enforcement, SUD, and

housing providers when serving individuals involved in the justice system. Participation in these meetings allows for increased coordination of care between systems and in supporting follow through of court order and/or CARE plans. Lastly, BHSA housing funds support and prioritize justice involved individuals who are engaging in alternative or diversion court processes. This includes housing units that are set aside for individuals in alternative or diversion courts, as well as prioritization in placement within the BHBH program for interim housing placements. County behavioral health teams engage in a monthly multi-disciplinary meeting specific to discussing housing availity and placements within the BHSA housing continuum of care. These meetings may also include representatives from FSP providers, homeless outreach providers, and supportive housing providers. During these meetings, upcoming bed availability is discussed and the by name list is reviewed to determine appropriate referrals for the upcoming available units.

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

CARE court referrals are generated by community members or agencies are filed directly with the court. If the court determines that a petition warrants an assessment of the individual identified within the petition, then the court judge orders county behavioral health staff to perform the assessment, and report back the findings of that assessment to the court and the first scheduled CARE hearing date. If a county behavioral health employee files a referral for CARE Court, assessment documentation in included within the referral packet, and a hearing date is scheduled. In both referral pathways, county representation from the forensic team is present at the initial hearing pertaining to the CARE referral. County forensic staff then follow through with the recommendation of the court, whether that be engaging the individual in the CARE Court process, alternative or diversion court process, or supporting them in accessing alternative supports within the community, as a participant is willing to engage.

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

The county behavioral health system has an existing, longstanding, and robust forensic program, which includes alternative and diversion courts for both mental health and substance use concerns. The forensic team works closely with the courts, the public defender, the district attorney, probation, full-service partnership providers, SUD provider, and other case management supports. These entities engage in regular multi-disciplinary team meetings for the purpose of case conferencing of individuals who are engaged with the justice system and may be eligible to alternative or diversion courts, as well as ongoing care coordination and status updates for individuals who are currently engaged in alternative courts. The county forensic team documents engagement and connection to services through their electronic health record, in addition to monitoring and receiving available court documents related to the individual engaged in alternative courts. Additionally, system level analysis for efficacy of work flows and

programming, as well as improvements to data sharing capabilities between systems are reviewed at bi-monthly collaborative meetings through the Stepping Up Initiative.

County Behavioral Health Technical Infrastructure

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

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

Please select which of the following EHRs the county uses
SmartCare

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

Please select which QHIO the county participates in
Connex
SacValley MedShare

Application Programming Interface Information

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

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://www.nevadacountyca.gov/2170/Quality-Assurance

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

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

County Behavioral Health System Service Delivery Landscape

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

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

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

Please select all services the county behavioral health system plans to provide under the PATH grant
Case Management Services
Outreach services

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

Community Mental Health Services Block Grant (MHBG)

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

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

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

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

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

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

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

Opioid Settlement Funds (OSF)

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

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Connect People Who Need Help to The Help They Need (Connections to Care)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

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

Bronzan-McCorquodale Act

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

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

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

Public Safety Realignment (2011 Realignment)

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

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

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management

m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

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

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

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

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

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services

h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Peer Support Services
Recovery Incentives Program (Contingency Management)

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

Other Programs and Services

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

Program or service
Homelessness Program/Homeless Outreach and Medical Engagement Team

Care Transitions

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

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

Yes

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

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

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

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

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

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

Mark page as complete

Priority statewide behavioral health goals for improvement

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

Access to care: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

Please describe other
Written Language

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For all measures, disparity data were extracted from the CalMHSA Access to Care PowerBI Dashboards, which utilizes 2022 data.

SMHS Penetration Rates [Adults] – Demographic groups performing below the county rate (5.0%) are residents aged 65+ (3.5%), Females (4.6%), and Hispanic (3.7%) residents.
SMHS Penetration Rates [Youth] – Demographic groups performing below the county rate (5.1%) are children aged 6-11 (4.2%), 3-5 (2.7%), Males (4.8%), Hispanic (5.0%) residents, and residents with unknown race/ethnicity (2.5%).
NSMHS Penetration Rates [Adults] – Demographic groups performing below the county rate (19.9%) are residents aged 21 – 32 (19.5%), 57-68 (17.6%), 69+ (10.9%), Males (14.5%), and Asian or Pacific Islander (9.9%), Hispanic (16.4%), and residents with races other than those specified (16.4%), individuals whose written language is Spanish (8.5%).
NSMHS Penetration Rates [Youth] – Demographic groups performing below the county rate (13.9%) are children aged 6-11 (9.5%), 3-5 (4.4%), Males (12.9%), Hispanic (9.6%), residents with races other than those specified (8.3%).

Key group disparities of note for potential intervention include individuals age 3-5 or age 65+ (below penetration rate for SMHS and NSMHS), adult males (for SMHS and NSMHS), and adult Hispanic (SMHS and NSMHS) or Asian/Pacific Islander (NSMHS) individuals. These disparities identified in Nevada County mirror patterns seen broadly across California counties, suggesting these gaps are reflective of systemic statewide trends rather than being unique to Nevada County alone.

Access to care: Cross-Measure Questions

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

Nevada County Behavioral Health (NCBH) launched the Behavioral Health Access Team (BHAT) in January 2026. This team is a dedicated access team for adults seeking county behavioral health services, and will greatly improve access to county behavioral health services. The Behavioral Health Access Team will have daily walk-in hours for screening and assessments, perform field-based outreach and assessment, and conduct follow-ups for individuals experiencing a behavioral health crisis. NCBH also opened the Commons Resource Center, a community day services hub dedicated to supporting individuals experiencing homelessness through compassionate care, peer support and essential services. The Commons Resource Center staffing is funded by BHSA dollars, and is run exclusively by peer supporters to provide a welcoming environment for essential services, as well as increase exposure to behavioral health services. The county's Homeless Outreach and Medical Engagement (HOME) team is located at the Commons Resource Center, and includes an embedded substance use counselor who can connect individuals to substance use treatment and Medication Assisted Treatment (MAT).

NCBH has also identified a need to increase access to substance use disorder services for youth. Although the county's youth DMC-ODS penetration rate is above the state average, there is statewide opportunity for increased access and engagement of this population, as NCBH has determined from focus groups and interviews that many adults with significant behavioral health needs in our county started use as young teenagers. As a result, NCBH has convened a Substance Use Disorder (SUD) youth workgroup cofacilitated by Nevada County Public Health with local high school counselors, providers supporting youth with SUD needs, juvenile probation, and Children's Behavioral Health. Over the last year, this work group has identified the lack of an established process for identifying youth in need of treatment, since the state directed screening tool (Brief Questionnaire for Initial Placement or BQUIP) does not contain youth specific questions. There is also a need for treatment for youth that is specifically tailored and meaningful for youth,

with simultaneous challenges around economies of scales to develop this type of targeted treatment. Looking forward, this workgroup will work to implement a youth-specific SUD screening tool (CRAFFT), enhance the transition bridge between referring providers like the school and SUD treatment, and embed SUD providers with Children's Behavioral Health to provide services on school sites.

More broadly, NCBH is focused on increases integration of mental health and substance use treatment, and is investing in a year long training series to increase county provider knowledge of substance use needs, reduce stigma, and increase clinical proficiency in treatment strategies.

Finally, NCBH will continue to invest in various justice involved initiatives to increase access to care for those with justice involvement. These initiatives include participation in the new CalAIM Justice Involvement initiative to increase warm handoff services in the jail, connecting individuals more directly from jail to behavioral health treatment, as well as continued involvement and leadership in the Stepping Up initiative, whose goal is to reduce the number of individuals with behavioral health needs in jails.

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

BHSA Behavioral Health Services and Supports (BHSS)
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
State General Fund
Other
Substance Use Block Grant (SUBG)

Please describe other

Enhanced Care Management, BHSOAC MAT Pilot Grant, PATH JI Grant

Homelessness: Primary measures

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

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

Above

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

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

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

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

Please describe other
English Learners, Students with Disabilities

Homelessness: Supplemental Measures

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

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

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

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

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

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

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

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

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

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For all measures, disparity data were extracted from the CalMHSA Homelessness PowerBI Dashboards, which utilizes 2024 data.

People Experiencing Homelessness PIT Count –Demographic groups performing above the County rate (26 per 10,000) are residents age 35-44 (51), residents 45 years and older (34), males (33), Alaskan Native or American Indian (103), Black (90), Native Hawaiian or Other Pacific Islander (76), residents identifying as multiple races (47), and White (36) residents.

Homeless Student Enrollment by Dwelling Type –Demographic groups performing above the County rate (3.3%) are students identifying as non-binary (8.0%), county residents who identified as Pacific Islander (6.6%), African American (6.3%), Hispanic or Latino (3.5%), youth identifying as two or more races (3.5%),

youth in transitional kindergarten (4.5%), Kindergarten (3.5%), Grades 1 (3.7%), 9 (3.4%), 10 (3.5%), 11 (4.0%) and 12 (4.2%), English language learners (5.0%), migrant students (9.3%), and students with disabilities (3.9%).

People Experiencing Homelessness Who Accesses Services from CoC – Demographic groups performing below the county rate (77 per 10,000) are residents 18-24 (72) and 65+ (32), and Asian or Asian American residents (18).

Key group disparities of note for potential intervention include Black/African American (unhoused adults and students) or Pacific Islander (unhoused adults and students) individuals, Alaskan Native or American Indian individuals (unhoused adults), non-binary individuals (unhoused students), and migrant individuals (unhoused students).These disparities identified in Nevada County mirror patterns seen broadly across California counties, suggesting these gaps are reflective of systemic statewide trends rather than being unique to Nevada County alone. Note that crude rates for small subgroups, such as Alaska Native or American Indian, Black, and Native Hawaiian rates for unhoused individuals should be interpreted with caution, as dramatic changes in rates may represent relatively few individuals.

Homelessness: Cross-Measure Questions

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

Nevada County Behavioral Health will continue to address homelessness through a variety of programs. The Homeless Outreach and Medical Engagement (HOME) Team will continue to offer outreach, medical support, care coordination, and housing supports to individuals experiencing homelessness with behavioral health needs. Additionally, Nevada County Behavioral Health will continue to fund homeless outreach programming through BHSA Early Intervention and/or Homeless Outreach and SAMHSA PATH via contracted providers to increase referrals to behavioral health services and housing. Nevada County Behavioral Health will continue to invest heavily in housing, through permanent supportive housing (106 beds), recovery residences (97 beds), board and cares, long term housing, and hotels/motels for individuals with behavioral health needs. NCBH has also received Homekey funds to add 24 new units of permanent supportive housing in FY 26/27, which will be supported through BHSA Housing Intervention funds.

In February of 2026, NCBH partnered with several local organizations including Volunteers of America, the Town of Truckee, Tahoe Forest Hospital, Placer County, and Fellowship of Compassion to open a Navigation Center in Truckee, a one-year pilot program serving individuals experiencing homelessness in Truckee and the North Tahoe region. The Navigation Center operates 24 hours a day, seven days a week, and provides a safe place for adults experiencing homelessness to stabilize while connecting to services and permanent housing. The Navigation Center offers 10 shelter beds, 6 interim housing beds, and day-use services including showers, meals, laundry facilities, and restrooms.

NCBH also recently opened the Commons Resource Center, a community day services hub dedicated to supporting individuals experiencing homelessness through compassionate care, peer support and essential services. The Commons Resource Center staffing is funded by BHSA dollars, and is run exclusively by peer supporters to provide a welcoming environment for essential services, as well as increase exposure to behavioral health services. Within this three-year plan, NCBH is increasing funding to Commons Resource Center staffing for a housing navigator position to help connect center participants to housing resources. NCBH is also partnering with the Commons Resource staffing provider, SPIRIT, to identify additional funding opportunities to sustain services such as Community Supports Day Habilitation services. The county's Homeless Outreach and Medical Engagement (HOME) team is located at the Commons Resource Center, and includes an embedded substance use counselor who can connect individuals to substance use treatment and Medication Assisted Treatment (MAT). The HOME team meets regularly with county substance use disorder counselors to discuss treatment plans for shared clients or identify referrals to substance use treatment.

File Upload

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

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

Please describe other
Enhanced Care Management, BHSOAC MAT Pilot Grant, Opioid Settlement Funds, Other Local Entity Contributions, Homekey, Behavioral Health Bridge Housing (BHBH), Encampment Resolution Fund (ERF), Housing and Urban Development (HUD) grants, PATH CITED

Institutionalization

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

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

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

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

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

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

Conservatorships, FY 2021 - 2022

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

Temporary Conservatorships
Not Applicable

Permanent Conservatorships
Not Applicable

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

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

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

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Crisis Stabilization

For adults/older adults
Above

For children/youth
Not Applicable

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

Please describe other
Written Language

Institutionalization: Disparities Analysis

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

For all measures, disparity data were extracted from the CalMHSA Institutionalization PowerBI Dashboards. For the purpose of this analysis, less time per beneficiary is assumed to be worse, as it may correspond to less care or service received for a given individual in crisis.

SMHS Crisis Utilization, Crisis Intervention for Adults (DHCS), FY 2023 – No subgroups with available data had rates that were below the County average (172.4 minutes).

SMHS Crisis Utilization, Crisis Intervention for Children/Youth (DHCS), FY 2023 – Compared to the County average (199.2 minutes), lower rates of crisis intervention service utilization exist for the following groups: youth age 18 – 20 (178.6). No additional subgroups with available data had rates that were above the County average.

SMHS Crisis Utilization, Crisis Stabilization for Adults (DHCS), FY 2023 – Compared to the County average (32.5 hours), lower rates of crisis stabilization service utilization exist for the following groups: adults age 45-56 (31.6). No additional subgroups with available data had rates that were below the County average.

The available disparity data is relatively limited and somewhat difficult to interpret, so findings should be interpreted with caution and supplemented with additional data in the future.

Institutionalization: Cross-Measure Questions

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

Data from the local Crisis Stabilization Unit (including encounter counts and resulting 5150s), Mobile Crisis Unit (including requests for service and encounters), and psychiatric hospitalizations (total counts) were also reviewed in preparation for completion of this Integrated Plan. Based on these more recent data sources, psychiatric hospitalization counts have been stable from FY 22-25. Since the mobile crisis implemented in January 2024, there's been a slight decrease in crisis evaluations and CSU admissions. These data will be monitored and integrated into planning going forward where possible.

File Upload

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

As previously referenced, Nevada County Behavioral Health (NCBH) launched the Behavioral Health Access Team (BHAT) in January 2026. NCBH has partnered with a Health Information Exchange (HIE) called Sac Valley Med Share to obtain real time data about local emergency department visits with an associated behavioral health diagnosis. The BHAT team will conduct daily outreach to individuals with a recent crisis visit or emergency department visit who are not connected to county behavioral health services to attempt to connect them to appropriate care.

Nevada County Behavioral Health will continue to invest in its Crisis Stabilization Unit, crisis, and mobile crisis programs. Since launching the mobile crisis program in January 2024, Nevada County Behavioral Health has observed reductions in emergency department visits and law enforcement 5150s due to increased field-based crisis stabilization and de-escalation.

NCBH has developed a comprehensive data tracking system and dashboard to monitor hospitalization trends, including monitoring year-over-year trends in number of hospitalizations, lengths of stay, individuals with repeat hospitalizations, and hospitalizations among specific demographics. NCBH focuses on providing excellent care post-discharge from psychiatric hospital, coordinating or providing transportation upon discharge and ensuring connection to services for both new and existing clients. In FY 24/25 offered an appointment within 7 days of psychiatric discharge 95% of the time.

Additionally, Nevada County Behavioral Health received a $23 million grant through the Behavioral Health Continuum Infrastructure Program (BHCIP) to build a 16 bed facility, including an 8-bed Psychiatric Health Facility (PHF) and 8-bed Mental Health Rehabilitation Center (MHRC). This project is on track to break ground in late spring of 2026 and is targeted to open in fall of 2027. Nevada County Behavioral Health worked with DHCS on this innovative model of two co-located levels of care to meet the needs of rural Nevada County and surrounding counties. This facility will allow for local placements for individuals who need this level of care, which will support recovery and may reduce rates of future institutionalization due to increased access to local natural supports and easier care coordination with local treatment teams compared to institutions several hours away.

NCBH will continue to fund community-based programs to prevent or reduce institutionalization, including

a 16-bed Social Rehabilitation Facility Odyssey House and a 5-bed Peer Respite facility Insight Respite Center, which often also serve as step-down facilities from institutionalization. NCBH's Adult Full Service Partnership (FSP) provider also participates in Assisted Outpatient Treatment, a program that provides intensive, community-based services designed for individuals who would not otherwise seek mental health treatment on their own and are at risk of requiring a high level of care. NCBH also participates in CARE Court, a new civil court process designed to link individuals who have specific mental health diagnoses to county behavioral health services, under the oversight of a judge, for up to 24 consecutive months. NCBH partners with its FSP provider to offer 12 beds of intensive permanent supportive housing options with 24/7 onsite staffing by behavioral health providers.

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

BHSA BHSS
BHSA FSP
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
State General Fund
Other

Please describe other

Prop 30, BHCIP Grant, CARE Court

Justice-Involvement: Primary Measures

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

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

For adults/older adults

Below

For juveniles
Above

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

Justice-Involvement: Supplemental Measures

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

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

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

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

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

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

Justice-Involvement: Disparities Analysis

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

data that supported your analysis
For Arrest Rates, disparity data were extracted from the CalMHSA Justice-Involvement PowerBI Dashboards, which utilizes 2024 data. Data for Adult Recidivism Conviction Rate was sourced from the CDCR convictions dashboard, utilizing 2019-2020 data.

Adult Arrest Rates – Adult demographic groups performing above the County rate (2,246 per 100,000) include adults aged 18-19 (3,018), 20-29 (4,951), and 30-39 (5,303), and adult males (3,450).

Juvenile Arrest Rates – Juvenile demographic groups performing above the County rate (592 per 100,000) include juvenile males (805). At the population-level, the following demographic groups have higher arrest rates than the county: Black (6,456) and White (1,980) residents specifically, Black females (3,396), Black males (8,479), Hispanic males (3,219), and White males (2,948).

Adult and Juvenile Combined: For this measure, race/ethnicity-stratified rates are only available at the population level. The overall Nevada County population rate for adults and juveniles is 1,970 per 100,000.

Adult Recidivism Conviction Rate –Compared to the county recidivism rate (36.8%), Male (38.9%) individuals had higher three-year adult recidivism conviction rates compared to the County.

Key group disparities of note for potential intervention include Black male youth (high juvenile arrest rate). This disparity identified in Nevada County mirror patterns seen broadly across California counties, suggesting these gaps are reflective of systemic statewide trends rather than being unique to Nevada County alone. Note that crude rates for small subgroups, such as Black populations for arrests should be interpreted with caution, as dramatic changes in rates may represent relatively few individuals.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Nevada County Behavioral Health (NCBH) is a participant and leader of the Stepping Up workgroup, an interagency initiative to reduce the number of individuals with behavioral health needs in jail. NCBH's forensic team participates on several collaborative courts to reduce justice involvement for those with

significant behavioral health needs, including Mental Health Court, Drug Court, Mental Health Diversion, Department of State Hospital (DSH) Diversion, CARE Court, Assisted Outpatient Treatment (AOT), and Mandated Treatment Court (MTC)/Prop 36 Court. NCBH is also participating in the new CalAIM Justice Involved initiative to connect individuals to behavioral health services prior to their release from jail. NCBH has various staff specifically targeting the forensic population, including a forensic program manager, a forensic clinical supervisor, a jail-based therapist to facilitate assessments and warm handoffs, two forensic behavioral health case managers, and a case manager embedded within the Public Defender's office.

Nevada County Behavioral Health also has several upstream programs to attempt to reduce justice involvement for individuals with behavioral health needs. Since launching the mobile crisis program in January 2024, Nevada County Behavioral Health has observed reductions in emergency department visits and law enforcement 5150s due to increased field-based crisis stabilization and de-escalation. The Homeless Outreach Team (HOT), a multidisciplinary and interagency team, reviews local calls for law enforcement trends including high utilizers, and engages in targeted outreach and case management for individuals identified as needing additional support. Nevada County has launched two new day services centers in FY 2025/2026 for individuals experiencing homelessness, which may reduce homelessness-related arrests and provide a safe space for individuals to be during the day as well as obtain both essential services like laundry and showers and behavioral health services like peer support and groups.

NCBH also operates various housing interventions that support reduction in justice involvement. NCBH operates a 7-bed diversion house for individuals experiencing chronic homelessness with high recidivism in local jails, including onsite supportive services. NCBH also operates several low-barrier interim housing options to offer safe spaces particularly for unsheltered individuals.

NCBH is above the state average for juvenile arrests. As a team, the program managers from juvenile Probation, Child Welfare, and Children's Behavioral Health meet weekly to address community concerns surrounding youth who are being arrested. Children's Behavioral Health is also partnering in delivery of services to ensure there is strong collaboration within treatment delivery. Functional Family Therapy (FFT) is being added as a service that will support probation youth in delivering an evidenced based model of treatment for family therapy. NCBH has funding that has supported the Juvenile Justice Independent Living Program (JJ-ILP) - youth who are at risk of being placed on probation are able to utilize these services at school. Probation has joined weekly Special Multidisciplinary Alternative Response Team (SMART) meetings and are active members in supporting families through a prevention platform.

File Upload

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

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

Please describe other

DSH IST Grant, Enhanced Case Management, CARE Court, Judicial Council of California Funding, Community Corrections Partnership (CCP) Funding

Removal Of Children from Home: Primary Measures

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

How does your county status compare to the statewide rate?

Below

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

No Disparities Data Available

Removal Of Children from Home: Supplemental Measures

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

How does your county status compare to the statewide rate?

Below

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

Age
Sex
Race or Ethnicity

Child Maltreatment Substantiations (CWIP), 2022

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

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

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For all measures, disparity data were extracted from the CalMHSA Removal of Children from Home PowerBI Dashboards, using 2024 data.
Children in Foster Care PIT Count – All age groups in Nevada County show masked or not applicable incidence (rate = 0.1). These demographic groups with a masked or not applicable incidence could not be calculated because data were not available from the US Census Bureau Population Estimates program to estimate the denominator. The County overall rate is 175 per 100,000 children.

Open Child Welfare Cases SMHS Penetration Rate – Demographic groups performing below the County rate (34.4%) are females (30.0%) and White youth (33.9%). Suppressed rates, shown with a placeholder value of 1.0%, were not reported for youth aged 0-2 years, 18-20 years, and 3-5 years.

Child Maltreatment Substantiations – Demographic groups performing above the County rate (2.9 per 1,000) are youth under 1 (16.0); White (3.0) youth; and females (3.1).

Key group disparities of note for potential intervention include youth under 1 (child maltreatment substantiations). This disparity identified in Nevada County mirror patterns seen broadly across California counties, suggesting these gaps are reflective of systemic statewide trends rather than being unique to Nevada County alone.

Removal Of Children from Home: Cross-Measure Questions

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

Across the Nevada County Children's System of Care, there has been a movement to support children and families who are involved in the foster care system. Recently, Child Welfare, Juvenile Probation, Children's Behavioral Health and Foster Youth Services collaborated over the past 3 months on completing a County Policy Improvement Plan surrounding completing the assessment tool Integrated Practice-Child and Adolescent Needs and Strengths (IP-CANS) to fidelity as well as Child and Family Team (CFT) Meetings. This movement supports clients and families in reunification efforts as well as supporting treatment in order to reduce removal of children from homes by identifying significant needs prior to getting to the place of removal.

NCBH also funds several specialty mental health services to support families, including high fidelity wraparound services, and intensive services targeted to serve pre- and post-adoptive and guardianship children and families at risk of a Child Welfare Services referral with specialty focus on issues related to trauma, attachment and permanency for youth who have been removed from birth families, including Pathways to Wellbeing (formerly Katie A) children. In FY 26/27, NCBH will begin work to implement Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and Multisystemic Therapy (MST) to fidelity, which all support family reunification and reducing criminogenic behaviors.

NCBH additionally funds Early Intervention programs through BHSA aimed at reducing removal of children from home including perinatal depression treatment and family support and parenting education classes.

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

BHSA BHSS
BHSA FSP
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

State General Fund

Untreated Behavioral Health Conditions: Primary Measures

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

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

For the full population measured
Above

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

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

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

For the full population measured
Above

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
Above

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

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Disparity data were extracted from the CalMHSA Untreated Behavioral Health Conditions PowerBI Dashboards.

Adults Who Needed Help, FY21-23 – Compared to the County rate (50.6%), rates for adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in the past year are higher among residents aged 65+ (56.8%), male (57.2%), and Latino (51.5%) residents. Looking across race and sex, Latino females (71.2%) and White males (59.5%) all had higher rates than the County.

Key group disparities of note for potential intervention include Latino females (high rate of reporting needing help with no visits). This disparity is relatively unique to Nevada County in that it is not reflected in statewide trends.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Nevada County Behavioral Health (NCBH) launched the Behavioral Health Access Team (BHAT) in January 2026. NCBH has partnered with a Health Information Exchange (HIE) called Sac Valley Med Share to obtain real time data about local emergency department visits with an associated behavioral health diagnosis. The BHAT team will conduct daily outreach to individuals with a recent crisis visit or emergency department visit who are not connected to county behavioral health services to attempt to connect them to appropriate care. This approach aims to increase connections to treatment for those with behavioral

health needs who are not yet connected to treatment services.

NCBH is participating in a Performance Improvement Plan to increase the number of individuals receiving Peer Support services. Increasing peer support services in the county behavioral health system of care may increase access and interest in services, with peers serving as a model of how treatment can actually benefit individuals with behavioral health needs. Peers may also help reduce fear and stigma associated with seeking behavioral health treatment.

There was an identified disparity in untreated behavioral health conditions for Latino females in Nevada County. Nevada County Behavioral Health will continue to fund LatinX community health workers in both Western and Eastern Nevada County, also known as Promotoras, to increase education about behavioral health conditions and referrals to treatment. NCBH will also continue to provide bilingual Spanish therapy to individuals with behavioral health needs.

File Upload

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

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

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

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

For adults/older adults
Below

For children/youth
Below

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

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

For adults/older adults
Below

For children/youth
Not Applicable

Engagement In School: Primary Measures

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

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

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

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

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

Overdoses: Primary Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Below

Overdoses: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

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

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

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

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

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

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

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

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

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

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

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Not Applicable

For adults/older adults
Below

For children/youth
Below

Quality Of Life: Supplemental Measures

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

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

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured
Not Applicable

For adults/older adults
Below

For children/youth
Above

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured
Above

Suicides: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

For related policy information, refer to 3.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.
Overdoses

Overdoses

Please describe why this goal was selected
In addition to performing below the state rates for both the primary and supplemental indicators, overdoses was identified as concern from the 2024 Community Health Assessment from the local department of public health. This assessment noted that drug overdose is the 3rd leading cause of age-adjusted death in the county, and that accidental overdose deaths have been trending upwards in the county since 2019, highlighting the intensifying nature of the issue. Additionally, during the Community Program Planning Process, stakeholder feedback included overdoses as a top priority for local behavioral

health programming including a need for broader naloxone training, and more services and resources for individuals who are recovering from an overdose.

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
For all measures, disparity data were extracted from the CalMHSA Overdoses and Suicides PowerBI Dashboards, which utilize 2022 data.

All Drug-Related Overdose Deaths – Demographic groups performing above the county rate (48.3 per 100k) are Males (64.7), Black/African American (451.0), Hispanic (61.1), Asian/Pacific Islander (56.0), residents aged 50-54 (139.4), 45-49 (130.0), 30-34 (89.8), 40-44 (86.8), 55-59 (84.3), and 60-64 (73.9).

All Drug-Related Overdose ED Visits – Demographic groups performing above the county rate (263.4 per 100k) are White (312.0), residents aged 30-34 (502.8), 15-19 (475.5), 35-39 (453.0), 25-29 (426.9), 40-44 (368.8), 20-24 (290.6), and Males (262.5).

Key group disparities of note for potential intervention include individuals aged 45-54 (high overdose death rate), individuals aged 15-39 (high rate of ED visits), and Black/African American individuals (high overdose death rate). Note that crude rates for small subgroups such as Black/African American induvial should be interpreted with caution, as dramatic changes in rates may represent relatively few individuals.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Nevada County's Opioid Overdose Prevention Program leverages a number of strategies to reduce overdoses and overdose deaths, including:

- Distribution of naloxone and fentanyl test strips
- Training, education and outreach
- Capacity building with partner organizations
- Data surveillance and rapid response
- Coalition activities and information dissemination

Distribution of naloxone and fentanyl test strips: Nevada County utilized health supply vending machines to distribute free naloxone, fentanyl test strips and other free health supplies. The county's five vending machines are located in strategic areas of the county, including Truckee, North San Juan, Penn Valley and

two in Grass Valley. In addition to distribution through the vending machine program, Nevada County distributes naloxone to community members on demand through its office and mobile distribution as well as through its opioid overdose prevention trainings.

Training, education and outreach: Nevada County provides free trainings on opioid overdose prevention and how to use naloxone and fentanyl test strips. Last year, the county provided more than 60 trainings to over 3,000 people in Nevada County. Training are provided to community-based organizations, government agencies, businesses and schools (both staff and students). In addition to formal trainings, Nevada County staff also attend numerous outreach events and mobile clinics in the community to distribute and provide education on naloxone and fentanyl test strips. The county has developed the Know Overdose Nevada County website (www.KnowOverdoseNC.com) with a wealth of information on opioid overdose prevention, naloxone, fentanyl test strips, and local treatment options.

Capacity building with partner organizations: Nevada County has supported numerous community-based organizations, businesses, government agencies and educational institutions in becoming naloxone distributors through the Naloxone Distribution Project. In addition, Nevada County has provided train-the-trainers, technical assistance and developed educational materials for organizations to provide training on opioid overdose prevention and distribute naloxone to their constituencies. Examples of capacity building efforts include distribution of naloxone through food banks, working with local first responders to implement Naloxone Leave Behind programs and training local businesses to provide naloxone training to their employees.

Data surveillance and rapid response: Nevada County monitors ODMAP for suspected overdoses on a continuous basis and has developed protocols for rapid response in the event of a spike in overdoses. These protocols range from notification of coalition members through a listserv to developing countywide social media with spike alerts and working with partners to rapidly deploy naloxone distribution if there is concern about elevated overdose risk in specific geographic areas of populations.

Coalition activities and information dissemination: Nevada County facilitates the Know Overdose Nevada County Coalition, a cross-sector campaign that meets monthly to share community updates, upcoming events, information and to keep an ear to the ground on what is happening in the local drug landscape. This cross-sector coalition represents a network of information sharing for overdose rapid response or to learn about emerging issues as early as possible and coordinate on how to respond. As an example, the coalition identified Kratom/7OH as a community issues in early 2025 and developed materials to educate coalition and community members.

Nevada County Behavioral Health (NCBH) is also supporting several treatment interventions to reduce overdoses. Firstly, NCBH plans to continue to support local and out of county substance use residential beds. NCBH will continue to fund Recovery Residences, which are transitional housing for individuals in recovery. In FY 26/27, NCBH plans to fund 97 Recovery Residence beds, and will identify opportunities for

future expansions. NCBH has implemented an assertive field-based substance use treatment through a Behavioral Health Services Oversight and Accountability Commission (BHSOAC) Medication Assisted Treatment (MAT) Pilot grant that it will sustain. This program embeds a contracted substance use counselor with telehealth access to Medication Assisted Treatment (MAT) within the Homeless Outreach and Medical Engagement (HOME) team. The HOME team is based at the Commons Resource Center (CRC), a community hub dedicated to supporting individuals experiencing homelessness through compassionate care, peer support and essential services. Though based at the CRC, the HOME team also engages in field-based services including street outreach and treatment. The substance use counselor is able to assess individuals and offer same-day access via telehealth to a medical provider to obtain a MAT prescription, as well as provide support to individuals in obtaining their prescription including transportation and education.

Furthermore, Nevada County is contracted with the Aegis Treatment Centers Narcotic Treatment (NTP) program, which includes an open access clinic for opioid treatment and medication assisted treatment in a NTP licensed facility in located in Grass Valley. Individuals seeking service can have same-day access to medication assisted treatment (MAT) through this clinic based on medical necessity. Services include intake, assessment, care coordination, counseling, medication assisted treatment, recovery services, and patient education. This NTP facility specifically can administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine, naltrexone, disulfiram, and naloxone.

NCBH also launched the Behavioral Health Access Team (BHAT) in January 2026. NCBH has partnered with a Health Information Exchange (HIE) called Sac Valley Med Share to obtain real time data about local emergency department visits with an associated behavioral health diagnosis. The BHAT team will conduct daily outreach to individuals with a recent emergency department visit related to a substance use disorder, including a recent overdose, who are not connected to county behavioral health services to attempt to connect them to appropriate care. Notifications will also be sent to treatment team members for clients with emergency department visits due to substance use disorder who are currently receiving county behavioral health services to facilitate follow up and treatment coordination.

Lastly, NCBH is focused on upstream prevention by increasing access to substance use disorder services for youth, since many adults with significant substance use disorder needs started their use as youth or teenagers. NCBH has convened a Substance Use Disorder (SUD) youth workgroup cofacilitated by Nevada County Public Health with local high school counselors, providers supporting youth with SUD needs, juvenile probation, and Children's Behavioral Health. Over the last year, this work group has identified the lack of an established process for identifying youth in need of treatment, since the state directed screening tool (Brief Questionnaire for Initial Placement or BQUIP) does not contain youth specific questions. There is also a need for treatment for youth that is specifically tailored and meaningful for youth, with simultaneous challenges around economies of scales to develop this type of targeted treatment. Looking forward, this workgroup will work to implement a youth-specific SUD screening tool (CRAFFT), enhance the transition bridge between referring providers like the school and SUD treatment, and embed SUD providers with

Children's Behavioral Health to provide services on school sites.

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

1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other

Please describe other

BHSOAC MAT Pilot Grant, Opioid Settlement Funds

Community Planning Process

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

Stakeholder Engagement

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

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

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

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

Type of engagement
Focus group discussions

Date
9/9/2025

Type of engagement
Focus group discussions

Date
9/16/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/24/2025

Type of engagement
Survey participation

Date
9/24/2025

Type of engagement
Focus group discussions

Date
10/2/2025

Type of engagement
Focus group discussions

Date
10/3/2025

Type of engagement
Focus group discussions

Date
10/3/2025

Type of engagement
Focus group discussions

Date
10/6/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/6/2025

Type of engagement
Focus group discussions

Date
10/7/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/7/2025

Type of engagement
Focus group discussions

Date
10/8/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/8/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/14/2025

Type of engagement
Focus group discussions

Date
10/16/2025

Type of engagement
Focus group discussions

Date
10/17/2025

Type of engagement
Focus group discussions

Date
10/20/2025

Type of engagement
Focus group discussions

Date
10/20/2025

Type of engagement
Focus group discussions

Date
10/21/2025

Type of engagement
Focus group discussions

Date
10/21/2025

Type of engagement
Focus group discussions

Date
10/21/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/28/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/29/2025

Type of engagement
Focus group discussions

Date
11/3/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Adult Mental Health and Substance Use Advisory Board
Aegis
Agency 4 Area on Aging
Alta California Regional Center
AMI Housing, Inc/Nevada County Housing Development Corporation (NCHDC)
A-Team
Auburn Counseling
Boys and Girls Club
Bright Futures for Youth
California Heritage: Indigenous Research Project (CHIRP)
Children, Youth & Families at Risk/Early Intervention
Common Purpose
Community Beyond Violence
Community Collaborative of Tahoe Truckee
DSA&MSA- Labor Union
Foothill House of Hospitality dba Hospitality House
FREED Center for Independent Living
Gateway Mountain Center/Whole Hearts, Minds & Bodies
Gold Country Community Services dba Gold Country Senior Services
Granite Wellness
Homeless Resource Council of the Sierras
Insight Respite Center
Kindred Heart Therapy
Local 39 Labor Union
MEA- Labor Union
NAMI
NCBH
NCBH – Forensic

NCBH Staff
NCBH-Bilingual Children & Adults
NCPH: Children, Youth & Families at Risk/Early Intervention
NCSOS - Partners Family Resource Centers
Network Therapist
Nevada County Health Collaborative
Nevada County Pride
Nevada County Public Health
Nevada County Sheriff's Office
Nevada County Social Services/Child Welfare
Nevada County Superintendent of Schols Office- Youth Homeless Outreach
Nevada County Superintendent of Schools Promotoras
Nevada County Veterans Service Office
Overdose Prevention Coalition
Pathways
Progress House
Project MANA/Sierra Community House - Homeless in Truckee
Nevada County Public Health
Recover
Sierra College Human Resources
Sierra Community House Promotoras
Sierra Community House/Family Resource Center of Truckee
Sierra Community Housing
Sierra Family Therapy
Sierra Nevada Memorial Hospital Foundation- Social Outreach
Sierra Mental Wellness Group
SPEEDY Foundation
SPIRIT Peer Empowerment Center
Stanford Sierra Youth and Families
Stepping Up: Justice & Mental Health Collaboration
Tahoe Truckee Community Collaborative
Tahoe Truckee Education Association
Tahoe-Truckee Unified School District
Telecare Corporation
Triage/Crisis Line
Turning Point Community Programs
Victor Community Support Services
Veterans Service Organization
Walts Home
WUWC - Mental Health First Aid

WUWC - Spectrum Project - LGBTQ+

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

	City name
1	
2	
3	
4	
5	

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

If not, which required stakeholder/groups were you unable to engage in the planning process?
Disability insurers
Regional centers
The five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities.)
Higher education partners
Labor representative organizations

Disability insurers
Attempted but did not receive a response

Higher education partners
Attempted but did not receive a response

Labor representative organizations
Attempted but did not receive a response

Regional centers
Attempted but did not receive a response

The five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities.)
Stakeholder group is not applicable to county

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
Stakeholder engagement for the Integrated Plan primarily consisted of data collection, conducted between late August and early November 2025. Data collection methods included 16 focus groups, 8 key stakeholder interviews, 1 survey, and 1 demographic form. Results from this engagement was analyzed and summarized into a report, presentation slide deck, and infographic that were used to inform program planning and prioritization reflected in this Integrated Plan. Additionally, results from stakeholder engagement activities were directly integrated into FY26-27 RFPs for prospective providers, with applicants explicitly asked to address specific components of the community feedback in their programming. Meeting minutes provide insight into the data collection process. (Upload final CPPP report and "Nevada County Behavioral Health_Evalcorp Meeting Minutes_8.21.2025")

The results of the CPPP show that participants highlighted distinct strengths, such as Crisis Services and specific programs across the continuum of care. NCBH staff, case managers, volunteers, and leadership received widespread praise for compassion, collaboration, and effectiveness. The workplace culture of NCBH was described as safe, healthy, and innovative. External partners reported positive collaboration experiences, and it was noted that Nevada County offers a wide range of services.

However, participants identified several challenges. Housing emerged as the most critical need, with 92% of survey respondents rating it as a high priority. Participants reported barriers, including restrictive eligibility criteria that prevent early intervention, limited substance use disorder treatment options for youth, geographic service disparities (particularly in Tahoe-Truckee), and issues with bilingual staffing, especially Spanish-speaking providers.

Key recommendations included expanding successful program models, increasing Spanish-speaking services (especially in the Tahoe-Truckee Region), expanding education about clients' diagnoses and eligibility status, expanding community-based housing with supportive services, developing low-barrier SUD treatment specifically for Transitional Age Youth, and simplifying system navigation for clients and

providers.

During the CPP process, four stakeholders were not able to be engaged: 1) disability insurers, 2) higher education partners, 3) labor representative organizations, and 4) regional centers. Although these stakeholders could not be engaged, they were considered during the CPP process at the planning, recruitment, and report-writing stages.

At the planning stage, the stakeholder survey was tailored to Nevada County BHSA stakeholders, including disability insurers, higher education partners, labor representative organizations, and regional centers. Furthermore, the key informant interview guide was tailored to Nevada County BHSA stakeholders, including regional centers.

At the recruitment stage, multiple attempts were made to engage disability insurers, higher education partners, labor representative organizations, and regional centers. First, a disability insurer was emailed the stakeholder survey three times (9/24/25, 10/6/25, and 10/15/25). Moreover, a key informant interview was conducted with a representative of a regional center, which has analogous interests to those of disability insurers. Second, a representative of a higher education partner was emailed the stakeholder survey three times (9/24/25, 10/6/25, and 10/15/25). A focus group was conducted with 7 educators from the county, which provides representation of analogous interests to higher education partners. Moreover, 11 educators/teachers participated in the stakeholder survey. Third, three separate labor unions were each emailed the stakeholder survey three times (9/24/25, 10/6/25, and 10/15/25). Four separate focus groups were conducted with a total of 96 behavioral health provider participants from across the county, including a focus group with Spanish-speaking providers, whose interests are analogous to those of labor unions, as they represent the perspective of the behavioral health workforce. Additionally, 48 mental health service providers participated in the stakeholder survey. Fourth, a representative of a regional center was recruited to participate via a stakeholder survey and a key informant interview. A regional center representative was emailed the stakeholder survey three times (9/24/25, 10/6/25, and 10/15/25). A regional center representative was also asked to participate in a key informant interview. There were three outreach attempts to a regional center representative to request their participation in a key informant interview. An initial email was sent on 9/18/205. A second outreach attempt was made via a phone call and voice message on 10/14/25. A final email regarding participation in the key informant interview was sent on 10/29/25. A key informant interview was also conducted with a representative of independent living centers, whose interests are analogous to those of regional centers.

Finally, disability insurers, higher education partners, labor representative organizations, and regional centers were all considered during the analysis and report-writing stages. The analysis used in the report, along with the report-writing process and the finalized report materials, were designed to be as accessible and useful as possible to all BHSA stakeholders.

Upload File
Community Meeting Mentimeter Results.pdf
BHSA Community Meeting 2025_12_01.pdf
NCBH FY 25-26 CPPP Report Updated 3.6.26 Final.pdf

Local Health Jurisdiction (LHJ)

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

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

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
Nevada County Behavioral Health participated in a community partner assessment survey and community partner events to inform the CHA/CHIP, as well as periodic involvement in the CHA/CHIP steering committees.

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

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

Was data shared?
Yes

Stakeholder Activities

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

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

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development

of its IP **? Additional information regarding engagement requirements with other local program planning processes can be found in** Policy Manual Chapter 3, Section B.2.3
Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
The most recent LHJ's Community Health Assessment available was completed in 2024. Relevant results from this assessment were incorporated into a preliminary review of secondary data, along with the BHSA Population Indicators, and reviewed and shared internally to inform a preliminary assessment of local priorities and needs. For example, the Community Health Assessment included statistics and qualitative feedback about a lack of transportation for geographically isolated communities, which was included as part of the review of the Access to Care indicators. Results from the Community Health Assessment also provided additional context for the Homelessness priority goal, and the Engagement in Work, Social Connection, Overdoses, and Suicides additional goals.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

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?
Partnership is still in the process of finalizing its Community Reinvestment Plan which is due later in 2026. Nevada County Behavioral Health has participated in a MCP-wide survey to all County Behavioral Health leaders to gather input to inform Partnership's Community Reinvestment Plan. Additionally, Nevada County Behavioral Health participates in quarterly Partnership and County Behavioral Health meetings, at which Community Reinvestment planning and priorities are shared and discussed.

Comment Period and Public Hearing

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

Comment Period and Public Hearing

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

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

Date the draft Integrated Plan (IP) was released for stakeholder comment
3/31/2026

Date the stakeholder comment period closed
4/30/2026

Date of behavioral health board public hearing on draft IP
5/1/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting
Public Comment and Hearing Website Screenshot.png

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page
https://www.nevadacountyca.gov/473/Behavioral-Health-Services-Act

File Upload

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

Attach email

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

Stakeholder group that provided feedback
N/A

Summarize the substantive revisions recommended this stakeholder during the comment period
N/A

Stakeholder group that provided feedback
Department of Healthcare Services (DHCS)

Summarize the substantive revisions recommended this stakeholder during the comment period
Updates to budget template to correct errors; additional information added regarding strategy to address higher than average juvenile arrest rates in statewide behavioral health goals; additional detail added regarding FSP program descriptions

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

Substantive recommendations
N/A

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

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

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

4_Nevada County QI Workplan Final Feb 2026.pdf

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

No

Contracted BHSA Provider Locations

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

Services Provided

Number of contracted BHSA provider locations

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	6
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	10

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	6
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	1

All BHSA Provider Locations

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

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

8.3

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

Nevada's SMHS provider locations are not providing services that are covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS).

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

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**

b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**

c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

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

No

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

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

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

Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
No

If not, please describe how the county will monitor these providers for compliance with BHSA requirements
County will develop custom monitoring protocol for BHSA funded providers who do not participate in the county's Medi-Cal Behavioral Health Delivery System, incorporating differences in practice such as documentation standards and chart audit requirements. County will monitor these providers annually, and perform site visits every three years.

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

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General

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

Early Intervention Programs (EIP)
Children's System of Care (non-Full Service Partnership (FSP))
Adult and Older Adult System of Care (non-FSP)
Workforce, Education and Training (WET)

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Intensive Services for Youth - This program delivers comprehensive, specialty mental health services primarily targeted to serve pre- and post-adoptive and guardianship children and families at risk of a Child Welfare Services referral with specialty focus on issues related to trauma, attachment and permanency for youth who have been removed from birth families, including Pathways to Wellbeing (formerly Katie A) children. Specialty mental health services will be provided based on the established medical necessity for mental health services and will include mental health rehabilitative services including plan development, group services, therapy, psychosocial rehabilitation services, care coordination, caregiver psychoeducation and coaching, school consultation, and family support services. This is a specialized level of care and target population distinct from outpatient services provided by Nevada County Behavioral Health. This program will also provide Functional Family Therapy (FFT), a multisystemic intervention designed for at-risk youth who experience challenges with externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use) that require the engagement of the youth or family members' support system.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	130
FY 2027 – 2028	130
FY 2028 – 2029	130

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Peer Respite Center - The Insight Respite Center is a peer-centered program where guests seeking relief from symptom distress are treated as equals on their road to recovery. The Insight Respite Center offers alternative resources and a safe place to stay for up to 2 weeks for eligible adults that may prevent the need for hospitalization. Peer supporters, trained in trauma informed models, are available 24 hours per day, offering hope, compassion and understanding in a stigma free environment.

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

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

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served.

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided
Crisis, Mobile Crisis, and Crisis Stabilization (CSU) Services - Crisis and Mobile Crisis services are available in Nevada County 24/7 to anyone in the community in a behavioral health or emotional crisis. The Mobile Crisis Team is staffed by behavioral health professionals who are specially trained to respond to crisis calls related to behavioral health needs. The goal of the team is to de-escalate critical incidents in the community through safety planning, provide warm handoff referrals and follow up care. Mobile Crisis responses increase opportunities for crisis stabilization in the community and decrease visits to the emergency department as well as 5150 holds. For those in need of more support, in person assessments can also occur at local emergency departments, including 5150 holds and referrals to hospitals where appropriate. Additionally, the Crisis Stabilization Unit (CSU) is a 23-hour program in Grass Valley that provides emergency psychiatric care in a warm, welcoming environment for individuals experiencing a behavioral health crisis. The four-bed Crisis Stabilization Unit provides more in-depth treatment to individuals while behavioral health crisis workers determine if they need to be transferred to a psychiatric hospital or can stabilize through outpatient services.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	1200
FY 2027 – 2028	1200
FY 2028 – 2029	1200

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
Projected numbers served were based on historical FY 24/25 data regarding numbers served.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy

Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
LatinX Outreach

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

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

Please describe intended outcomes of the program or service
This program intends to increase behavioral health access, engagement, linkage and early intervention for Latinx community members in Nevada County by reducing cultural, linguistic, and systemic barriers enhancing awareness of behavioral health services, and promoting equity in service utilization. Services include development of Wellness Recovery Action Plans (WRAP), substance use outreach and education, individual and family case management and referrals to services, workshops, support groups, and peer support.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	530
FY 2027 – 2028	530
FY 2028 – 2029	530

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

Senior, Disabled and Isolated Outreach

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

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

Please select the EBPs and CDEPs that apply
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
PEARLS

Please describe intended outcomes of the program or service
The Senior, Disabled and Isolated Outreach program will target outreach to older adults, adults with disabilities, family members, caregivers, and organizations that serve the target population, and will contain two main programs: the Friendly Visitor program and the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS).

The Friendly Visitor program matches an isolated older adult or person with a disability with a trained volunteer who visits the individual in their home or calls to visit by phone once a week. This increased social interaction connects consumers with the support and resources they need to maintain their mental health, safety and independence. Outreach by a volunteer Coordinator, takes place year-around for volunteers. Friendly Visitor volunteers are screened, complete training and then are matched with a participant based on common interest. The Friendly Visitor Coordinator will complete an intake process with the older adult. By using motivational Interviewing techniques and person-centered counseling, they can Identify needs and set goals with the consumer and strategies for addressing them. Participants are screened using the PH-Q2, and those who qualify due to their level of symptoms of depression, are offered to participate in the PEARL's Program, an intervention for seniors with a depression or dysthymia diagnosis which aims to reduce symptoms of depression and suicidal ideation and improve quality of life. This program includes problem-solving treatment, social and physical activation, and pleasant activity scheduling. PEARLS participants will meet one-on-one with a trained facilitator or join an ongoing group for eight 50- minute sessions. Both programs provide frequent contact with the consumer so that appropriate mental health interventions and services can be offered as the need arises.

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

No

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

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

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

Perinatal Depression Intervention

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals

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

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

Please select the EBPs and CDEPs that apply
Cognitive Behavioral Therapy (CBT) for Depression

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Cognitive Behavioral Therapy

Please describe intended outcomes of the program or service
This program will implement "Moving Beyond Depression (MBD)", an evidence-based intervention for pregnant women and new mothers experiencing perinatal mood and anxiety disorders (PMADs), including depression, anxiety, OCD, and PTSD. Maternal mental health is a critical yet often overlooked component of both maternal and child well-being, with PMADs affecting up to 20% of new mothers and carrying significant consequences for maternal functioning and child emotional and cognitive development.
MBD provides voluntary, in-home cognitive behavioral therapy (IH-CBT) delivered by a trained licensed therapist in coordination with active home visiting services. This integrated model reduces barriers to care, improves engagement, and addresses symptoms within the context of early parenting and family systems. The program supports clients from screening and early intervention through symptom reduction and recovery.
The program will also incorporate a group component, Becoming Us™ , using a curriculum developed by Ellie Taylor , a nationally recognized perinatal mental health expert. This component addresses the significant stress experienced by new parents, by offering preventative support aimed at strengthening relationships and emotional well-being prior to birth. Data indicate that approximately one in four families experience separation during the first year of parenting. By intervening early, Becoming Us™ helps reduce the risk of childhood trauma, family dissolution, and domestic violence—outcomes that can emerge during the intense transition to new parenthood. This portion of the program is open to all parents, without a home visiting requirement.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	45
FY 2027 – 2028	45
FY 2028 – 2029	45

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

Indigenous Outreach

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments

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

Please specify "other" type of Treatment Services and Supports
Group supports and peer support embedded in cultural programming; skills-building and resilience practices; brief interventions that reduce distress and strengthen functioning.

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

Please describe intended outcomes of the program or service
This program will deliver early intervention services for Indigenous People in Nevada County, including Tribal members and other Indigenous residents in the western county region (Nevada City and Grass Valley communities). Services will be delivered through a mix of community-based outreach, land-based and community-centered group supports, individual navigation and case management, and coordinated referral pathways to County and community providers. Core activities will include:
Outreach and engagement: relationship-based outreach through community gatherings, cultural activities, and peer-to-peer engagement to identify early signs of distress and reduce stigma.
Screening and early identification: PHQ-9, GAD-7, and other brief tools as appropriate; warm handoffs to assessment and services.
Assessment and service planning: biopsychosocial and social determinants of health assessment; collaborative service plans that reflect cultural values and client priorities.
Access and linkage: navigation support, referral coordination, appointment support, and follow-up to increase successful engagement with services.
Culturally responsive supports: talking circles, peer support, family support and education, cultural workshops that strengthen connection and protective factors.
Co-occurring mental health and substance use supports: harm reduction education, linkage to treatment/recovery supports, and coordination with DMC-ODS resources as appropriate.
Flexible supports (as allowable): limited flexible funds to address barriers identified in service plans (e.g., transportation, incentives, housing stabilization supports) to enable successful access and engagement.
Systems-building and training: cross-cultural Tribal Service Provider Coalition and trainings/educational materials for County

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	40
FY 2027 – 2028	40
FY 2028 – 2029	40

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

Family Support and Family Strengthening (Eastern County)

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals

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

No

Please describe intended outcomes of the program or service

This program provides responsive, accessible parenting education, support and engagement opportunities to families, including under-served and high-need populations, in Nevada County. The program will strengthen parent/caregiver skills, enhance child development outcomes, increase family resilience, and link families to broader behavioral health and community resources. The program will build protective factors, reduce risk factors, improve access to care, and improve outcomes for children, youth, and families. The program will provide family–centered outreach, playgroups, support groups, and parenting education for families with young children, prioritizing children ages 0-5, families involved in the child welfare system, families experiencing homelessness, and those with high levels of Adverse Childhood Experiences (ACEs). The program will reduce family isolation, strengthen peer support networks, and build caregiver knowledge, skills, and confidence. Classes will function as first point of contact to the broader continuum of care. Facilitators will provide referrals and navigation support for health coverage enrollment, mental health services, childcare resources, and other community-based systems. Ongoing engagement activities, including Family Room, Teen Dads Group, Mom's Cafe, Co-Parenting Peer Support and Youth Support Groups build social support networks for caregivers, strengthen protective factors and promote social-emotional and developmental well-being in children and youth. Services are offered in English and Spanish and targeted to low-income and Latinx families to promote equity and reduce disparities. Education and child development will be integrated to strengthen protective factors associated with prevention of child abuse and neglect. Additionally, these programs utilize strategies that foster knowledge of child development which is a protective factor against child abuse.

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

No

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

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	170
FY 2027 – 2028	170
FY 2028 – 2029	170

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

School-Based Wellness Center (Eastern County)

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

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

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

Please select the EBPs and CDEPs that apply
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Cognitive Behavioral Interventions for Trauma in Schools (CBITS), Dialectical Behavior Therapy (DBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Motivational Interviewing (MI), Youth Mobile Crisis Response (YMCR)

Please describe intended outcomes of the program or service
A team of five licensed and associate clinicians serve as Tahoe Truckee Unified School District (TTUSD) Mental Health Specialists, providing intensive, evidence-based therapeutic services across all TTUSD K–12 school campuses. The Mental Health Specialists support students experiencing the early signs of a mental health or substance use disorder, complex family stressors, and/or childhood trauma. Their role encompasses clinical assessment, short-term individual and group therapeutic interventions, safety assessments, and comprehensive case management to help students and families navigate vital community systems of support.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	185
FY 2027 – 2028	185
FY 2028 – 2029	185

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

Veterans Services and Therapy

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

Outreach
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
Access and Linkage: Referrals
Access and Linkage: Assessments

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

Please describe intended outcomes of the program or service
This program focuses on veterans who are experiencing early signs of behavioral health concerns, including trauma-related stress, anxiety, depression, and elevated suicide risk, with the goal of stabilizing veterans early and supporting them in thriving in their post-military careers and lives.

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

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

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

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name
Behavioral Health Screenings in Schools

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

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

Please describe intended outcomes of the program or service
This program offers no cost, universal screenings to 9th grade students enrolled at Nevada County high schools. A screening team of mental health clinicians and counselors will provide students confidential, individual, in-school behavioral health assessments. The universal, in-school behavioral health screenings are specifically designed as a comprehensive early detection strategy for youth. Student screenings include 1) taking an online evidence-based screening tool that identifies early onset behavioral health symptoms and impairments 2)confidential one-on-one meetings with licensed clinicians, registered associates, a registered psychiatric nurse, or mental health counselors. This meeting is a thorough review of screening results with students, determining what interventions are required or desired 3) case management services to identify appropriate interventions for students and families aimed at reducing behavioral health challenges and risks. As applicable, case management will provide early intervention for students and their families, linking them to mental health and other resources in the community. The program will provide in-school support groups at schools including mindfulness, anti-racism/anti-bullying, LGTBQ+, and expressive arts support groups.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	400
FY 2027 – 2028	400
FY 2028 – 2029	400

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

Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Early Intervention (EI) Programs

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

Program or service name

Youth Homeless Case Management

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

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

Please specify "other" type of Treatment Services and Supports
Housing Stabilization and Housing Navigation, stabilization and wraparound supports

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

Please describe intended outcomes of the program or service
This program will address basic needs and stabilizing support services, case management and individualized case plans, social-emotional support, education to promote mental wellness and substance use prevention, and life skills development for youth, particular those experiencing housing instability. The primary purpose of this program is to provide centralized case management for youth to identify needs early, provide timely supports, and coordinate access to appropriate services, thereby reducing the duration of untreated mental health and substance use disorders and supporting youth in quickly regaining stability, functioning, and connection to school, family, and community.

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

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

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

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected numbers served were based on historical FY 24/25 data regarding numbers served as well as proposals in response to a request for proposal process.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

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

CSC program name
Coordinated Specialty Care for First Episode Psychosis (CSC) Program

CSC program description
Nevada County's contracted Coordinated Specialty Care for First Episode Psychosis (CSC) Program will be delivered primarily via telehealth with in-person services being provided based on meeting program fidelity requirements to meet the diverse needs of individuals and families, including rural and underserved communities. The program will serve individuals experiencing their first episode of psychosis (FEP), as well as those who may be at elevated risk for developing psychosis due to current symptoms, functional decline, or personal and family history, utilizing evidence-based treatment models for early psychosis and mood disorder detection and intervention. The program will provide recovery-oriented direct services to youth and young adults in need of early psychosis care who meet specialty mental health services (SMHS) criteria and have Medi-Cal or are uninsured. Services will include, but are not limited to, medication management, psychotherapy, case management, family education and support, peer support, and supported employment and education.

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

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

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	12
Number of Uninsured Individuals	<11*

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

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	3	3	3
Total Number of Teams	1	1	1

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

Please list the other funding source(s)
FFP, MHBG

County Workforce, Education, and Training (WET) Program

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

Program or activity name
BHSA Implementation Innovation Plan (Encumbered MHSA Innovation Project)

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
This project is an encumbered MHSA Innovation project, approved by the Behavioral Health Oversight and Accountability Commission (BHSOAC) on 11/21/24 and operating from 1/1/2025 through 6/30/2027. This approach applies a learning collaborative model which has proven to be effective in various statewide grant models and will tailor the model to local community-based organizations who have minimal administrative infrastructure. Learnings such as guides to Medi-Cal programs, policy and procedure templates, success with providers, and efficacy of incentives can be shared statewide and applied in other communities. This innovative project will guide formerly Mental Health Services Act (MHSA) funded providers, particularly early intervention providers, in transitioning to a Medi-Cal fee-for-service model. By focusing on this goal, Nevada County Behavioral Health (NCBH) aims to help these providers enhance their self-sufficiency and ensure they can continue delivering essential services. NCBH has contracted with a third party agency to facilitate a learning collaborative with participating providers to explore and implement options for Medi-Cal billing through a variety of pathways, and will offer providers deliverable-based incentives to support their participation in the collaborative and to close identified gaps such as the need for an Electronic Health Record. This collaborative will specifically address disparities in the Behavioral Health workforce by increasing long term sustainability for early intervention providers serving historically underserved and underrepresented populations.

Full Service Partnership Program

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

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

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	251
Number of Uninsured Individuals	31
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	65

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

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

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	31

ACT Eligible Population	Estimates
Number of Uninsured Individuals	<11*

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	15
Number of Uninsured Individuals	2

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

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	9	9	9
Total Number of Teams	5	5	5

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	205
Number of Uninsured Individuals	25

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	10

FSP ICM Practitioners and Teams Needed	Estimates
Number of Teams Needed to Serve Total Eligible Population	2

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	11	11	11
Total Number of Teams	4	4	4

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	130

HFW Eligible Population	Estimates
Number of Uninsured Individuals	<11*

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	49
Number of Teams Needed to Serve Total Eligible Population	2

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	21	21	21
Total Number of Teams	9	9	9

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	288
Number of Uninsured Individuals	40

IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	23
Number of Teams Needed to Serve Total Eligible Population	9

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

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

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

Full Service Partnership (FSP) Program Overview

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

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

Please describe how the estimated practitioners will provide more than one EBP
There may be overlap between practitioners who are delivering ACT, FACT, IPS, and FSP ICM services, largely due to the low volume of estimated individuals with clinical need. For example, an ACT or FACT team comprised of 10 behavioral health practitioners and is intended to support a caseload of 100 individuals, while Nevada County's only has an estimated need of 31 Medi-Cal individuals. There is one unified contracted provider delivering ACT, FACT, IPS, and FSP ICM. This provider will ensure that all staff are cross-trained in the various areas as needed for their role and possible overlap, such as training ACT/FACT/ICM providers on IPS-aligned functions and supports, and cross training ICM providers in ACT/FACT modalities for coverage purposes as well as continuity of care through level of care transitions.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
All FSP programs implement trauma-informed care. Specific strategies include the use of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), shared decision making, and strengths-based service planning. Programs will evaluate for whole-person needs including housing needs, family needs, employment, education, connection to physical health care.

The HFW program will incorporate Caregiver Peer Partner/Peer Support Specialists who will work with any families who are identified as having significant caregiver needs as part of their referral and/or have actionable IP-CANS ratings (2 or 3) in the Caregiver Needs IP-CANS domains. They elevate the client and family's voice in the Wraparound process, ensuring their needs are met. They act as partners in the design and implementation of the family service plan and alongside the clinical team, child welfare, probation

officers, law enforcement, etc., to ensure that the family's voice is heard and respected and that the behavioral health needs of families and their children are met with the appropriate support, such services that reflect their cultural,
religious, and/or language needs. The CPP/PSS is a former consumer of services from probation, CPS, or mental health and act as experts in the "lived experience" of the families receiving Wraparound services. The CPP/PSSs bring personal experience, which is critical to the process of engaging with families and bridging the gap that can occur between consumers and providers of social services. The CPP/PSSs will 1) contact and engage with family, caregivers, and client to determine their service needs; 2) assess for any gaps in parental or client service expectations; and 3) work with the Facilitator to tailor the meetings to be needs based; services should meet the needs of the family. The CPP/PSS informs the CFT of the family's support needs and collaborates with the CFT to address any potential barriers to engagement in the Wraparound process.

The Adult FSP program will incorporate a Family Advocate, who provides education, support, and advocacy to family members and natural supports of enrolled participants, consistent with participant consent. The Family Advocate facilitates family engagement, supports WRAP development with families, and participates in Family Team Meetings and monthly family support groups. Family Advocates provide recovery-oriented, non-clinical support to family members and identified natural supports of participants, recognizing the critical role families and support systems play in engagement, stability, and recovery. Family Advocates offer education about serious mental illness, recovery processes, and available services; support family members in navigating behavioral health and community systems; and promote effective communication and collaboration between participants, families, and the treatment team, consistent with participant consent and confidentiality requirements.

Each FSP program embeds Peer Support Specialists to contribute to a recovery-focused perspective informed by lived experience of recovery. The Adult FSP program utilizes the Milestones of Recovery Scale (MORS), informed by the Eight Determinants of Care, to support understanding of recovery status, engagement, and functional stability over time. The MORS provides a shared, longitudinal view of recovery and engagement that supports consistent discussion of service intensity across the team. At the Providence Center, MORS supports clinical discussion and continuity of care but is not used as a standalone placement tool.

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

Nevada County FSP services will align services and strategies with cultural values and preferences. Additionally, FSP providers will evaluate demographics of participants and stratified outcomes by demographics. BHP will include in FSP contracts that all providers will attend NCBH's cultural competency program, participate in trainings and tailor outreach efforts and marketing materials to engage a diverse population of community members. Also, during monthly contract monitoring meetings, the BHP will discuss the interventions utilized with different identified cultures and have the FSP share real case

scenarios in which these interventions were used. Examples of culturally respectful and informed services and supports that will be implemented are psychosocial rehabilitation groups that leverage students' cultural backgrounds and home languages such as using cultural examples and scenarios to enhance interpersonal relationship building or incorporating group therapeutic materials that reflect cultural backgrounds as identified through the demographic reports.

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

Access to care
Homelessness
Overdoses
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions
Care experience
Engagement in school
Engagement in work
Prevention of co-occurring physical health conditions
Quality of life
Social connection
Suicides

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

Individuals receiving FSP ICM services will still receive comprehensive engagement and services, including individualized case management, service coordination, housing stabilization and tenancy support, benefits advocacy, skill-building related to daily living and community integration, linkage to community-based services, and support during transitions between levels of care. Contacts are typically provided weekly or more frequently as needed, with flexibility to increase intensity during periods of destabilization.

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

Ongoing engagement across all of these EBPs is expected to be thorough for all participants, with most participants receiving at least one weekly service. Engagement will include medication delivery, care coordination, transportation support, skill development, groups, family engagement, and housing coordination.

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

The Adult FSP provider will utilize the Milestones of Recovery Scale (MORS), informed by the Eight Determinants of Care, to support understanding of recovery status, engagement, and functional stability over time. The MORS provides a shared, longitudinal view of recovery and engagement that supports consistent discussion of service intensity across the team. Level-of-care determinations are guided by clearly defined clinical and functional factors, including:

- Clinical acuity and risk, including severity and persistence of symptoms, recent psychiatric hospitalizations, and frequency of crisis or emergency service use
- Functional impairment, including ability to complete activities of daily living, manage personal affairs, and function safely in the community
- Housing stability and retention risk, including homelessness, imminent risk of housing loss, or need for intensive supports to obtain or maintain housing
- Engagement capacity, including ability to participate in services without assertive outreach and the need for shared team responsibility
- Co-occurring conditions, including substance use, medical complexity, or cognitive impairment that increase service coordination needs
- System involvement, including justice system involvement or need for intensive coordination with courts, probation, or other systems of care
- Intensity of coordination required, including need for multidisciplinary, team-based intervention versus individualized case management

Participants demonstrating high acuity across these factors, supported by MORS and multidisciplinary clinical review, are prioritized for ACT or FACT. Participants whose needs can be effectively met through frequent, relationship-based support without full team intensity are prioritized for a lower-intensity ACT-informed model aligned with FSP Intensive Case Management. These factors are reviewed collectively by the multidisciplinary team during structured case review to determine initial placement and to support planned movement between ACT/FACT and FSP ICM levels of care over time. Results from standardized tools are reviewed in conjunction with these clinical and functional factors through clinical supervision and multidisciplinary team discussion, with tool outputs used to inform—rather than determine—final level-of-care decisions. Decisions are based on patterns of indicators reviewed collectively by the team, not on a single score or threshold.

The Adult FSP provider may also implement other tools as recommended by the Department of Health Care Services (DHCS) or the Centers of Excellence such as the Level of Care Utilization System (LOCUS) and/or the Adult Needs and Strengths Assessment (ANSA).

Please indicate whether the county FSP program will include any of the following optional and allowable services
See responses below:

Primary substance use disorder (SUD) FSPs
No

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

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
The Adult FSP program operates the Assisted Outpatient Treatment (AOT) program, which provides intensive, community-based services designed for individuals who would not otherwise seek mental health treatment on their own and are at risk of requiring a high level of care.

Other recovery-oriented services
No

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

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

In, or at-risk of being in, the juvenile justice system
Through its community planning process, Nevada County conducted focus groups with families of youth mental health and FSP participants and the Stepping Up workgroup which includes various youth criminal justice partners including Nevada County Probation and Nevada County Sheriff's office. Focus groups reviewed population health data including juvenile arrest rates, and provided feedback on strengths and gaps.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Through its community planning process, Nevada County conducted a key informant interview with a representative from Nevada County Pride, a social network of gay, lesbian, bisexual, queer, and transgender persons, and their allies, who celebrate and support the LGBTQ+ community in western Nevada County, California, including Grass Valley and Nevada City. Additionally, Nevada County conducted focus groups with providers of services to LGBTQ+ youth, including Bright Futures for Youth, Nevada County Behavioral Health staff, Nevada County Superintendent of Schools, Tahoe Truckee Unified School District, Stanford Sierra Youth and Families, and Victor Community Support Services.

In the child welfare system
Through its community planning process, Nevada County conducted focus groups with families of youth mental health and FSP participants, including families with child welfare involvement. Nevada County also conducted focus groups with organizations that partner closely with child welfare through multidisciplinary efforts, including Nevada County Behavioral Health staff, Stanford Sierra Youth and Families, Victor Community Support Services, and Nevada County Child Welfare itself.

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

Older adults
Through its community planning process, Nevada County conducted several focus groups with representation from older adults and/or providers serving older adults, including the Mental Health and Substance Use Advisory Board, Agency 4 Area on Aging, Turning Point, FREED, Nevada County Public Health, Nevada County Adult Services, and Gold Country Community Services.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Through its community planning process, Nevada County conducted a key informant interview with a representative from Nevada County Pride, a social network of gay, lesbian, bisexual, queer, and transgender persons, and their allies, who celebrate and support the LGBTQ+ community in western Nevada County, California, including Grass Valley and Nevada City.

In, or are at risk of being in, the justice system
Through its community planning process, Nevada County conducted a focus group with the Stepping Up workgroup which includes various criminal justice partners including Nevada County Probation, Nevada County Sheriff's office, Nevada County Courts, Nevada County District Attorney, and the Nevada County Public Defender. Nevada County Behavioral Health also obtained feedback from co-responder law enforcement teams, which pair a trained mental health crisis clinician with a Nevada County Sheriff's

Officer. Focus groups reviewed population health data including arrest rates, and provided feedback on strengths and gaps.

Assertive Field-Based Substance Use Disorder (SUD) Questions

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

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

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

Behavioral Health Access Team (BHAT), Homeless Outreach and Medical Engagement (HOME) Team

Program descriptions

The Behavioral Health Access Team (BHAT) will conduct daily outreach to individuals with a recent crisis visit or emergency department visit who are not connected to county behavioral health services to attempt to connect them to appropriate care. NCBH has partnered with a Health Information Exchange (HIE) called Sac Valley Med Share to obtain real time data about local emergency department visits with an associated behavioral health diagnosis, including substance use disorders and/or overdoses. If NCBH is made aware of an overdose, either through the HIE, client or family notification, or through partnership with the Yuba Harm Reduction Council, county substance use care coordinators will attempt to make immediate contact to refer the individual to care and residential treatment.

The Homeless Outreach and Medical Engagement (HOME) Team will continue to offer outreach, medical support, care coordination, and housing supports to individuals experiencing homelessness with

substance needs to attempt to connect them to treatment. The HOME team includes an embedded substance use counselor who can connect individuals to substance use treatment and Medication Assisted Treatment (MAT). The HOME team meets regularly with county substance use disorder counselors to discuss treatment plans for shared clients or identify referrals to substance use treatment.

Current funding source
Enhanced Care Management, FFP, 1991 Realignment, 2001 Realignment, Patient Care Revenue

BHSA changes to existing programs to meet BHSA requirements
NCBH will continue to enhance partnerships to obtain more real-time data on overdoses and overdose reversals to increase referrals to care.

Expected timeline of operation
1/1/2026

Mobile-field based programs

Existing programs
Field-Based MAT Telehealth Provider

Program descriptions
This program embeds a contracted substance use counselor with telehealth access to Medication Assisted Treatment (MAT) within the Homeless Outreach and Medical Engagement (HOME) team. The HOME team is based at the Commons Resource Center (CRC), a community hub dedicated to supporting individuals experiencing homelessness through compassionate care, peer support and essential services. Though based at the CRC, the HOME team also engages in field-based services including street outreach and treatment. The substance use counselor is able to assess individuals and offer same-day access via telehealth to a medical provider to obtain a MAT prescription, as well as provide support to individuals in obtaining their prescription including transportation and education.

Current funding source
Enhanced Care Management, FFP, BHSOAC MAT Pilot Grant, 1991 Realignment, Patient Care Revenue

BHSA changes to existing programs to meet BHSA requirements
As the BHSOAC MAT Pilot grant comes to a close, NCBH and its contracted provider will monitor Medi-Cal billing to ensure long term sustainability of the program.

Expected timeline of operation
7/1/2025

Open-access clinics

Existing programs
Aegis Treatment Centers Narcotic Treatment Program (NTP), Field-Based MAT Telehealth Provider

Program descriptions
The Aegis Treatment Centers Narcotic Treatment (NTP) program includes an open access clinic for opioid treatment and medication assisted treatment in a NTP licensed facility in located in Grass Valley. Individuals seeking service can have same-day access to medication assisted treatment (MAT) through this clinic based on medical necessity. Services include intake, assessment, care coordination, counseling, medication assisted treatment, recovery services, and patient education. This NTP facility specifically can administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine, naltrexone, disulfiram, and naloxone.

The Field-Based MAT Telehealth program embeds a contracted substance use counselor with telehealth access to Medication Assisted Treatment (MAT) within the Homeless Outreach and Medical Engagement (HOME) team. The HOME team is based at the Commons Resource Center (CRC), a community hub dedicated to supporting individuals experiencing homelessness through compassionate care, peer support and essential services. Though based at the CRC, the HOME team also engages in field-based services including street outreach and treatment. The substance use counselor is able to assess individuals and offer same-day access via telehealth to a medical provider to obtain a MAT prescription, as well as provide support to individuals in obtaining their prescription including transportation and education.

Current funding source
Enhanced Care Management, FFP, BHSOAC MAT Pilot Grant, 1991 Realignment, 2001 Realignment, Patient Care Revenue

BHSA changes to existing programs to meet BHSA requirements
NCBH will continue to enhance referrals and warm handoffs to both programs.

Expected timeline of operation
7/1/2025

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Mobile-field based programs

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Open-access clinics

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

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

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
NCBH will monitor timeliness data for OTP/NTP services, specifically the time from request for NTP/OTP service to first offered appointment. Additionally, NCBH will monitor the need for expansion of contracted MAT providers, such as an expansion of the embedded SUD Counselor within the HOME team with access to MAT via telehealth. Nevada County will monitor related HEDIS measure performance relative to state benchmarks, such as the OUD Measure which measure the percentage of members with an opioid disorder diagnosis that received 1+ dose of MAT medications, to identify gaps in MAT resources to address unmet needs. Additionally, Nevada County will continue to monitor population health indicators such as overdoes rates to measure unmet needs of individuals who are not yet in the system and may not yet have a diagnosis to help encourage more targeted outreach through the Behavioral Health Access Team and Homeless Outreach and Medical Engagement Team.

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

Contract directly with MAT providers in the County
Leverage telehealth model(s)

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

Buprenorphine
Methadone
Naltrexone
Other

Please specify other forms of MAT

Disulfiram, naloxone

Housing Interventions

Planning

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

System Gaps

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

Supportive housing

Small gap

Apartments, including master-lease apartments
Small gap

Single and multi-family homes
Small gap

Housing in mobile home communities
No gap

(Permanent) Single room occupancy units
Medium gap

(Interim) Single room occupancy units
Medium gap

Accessory dwelling units, including junior accessory dwelling units
Small gap

(Permanent) Tiny homes
Not applicable

Shared housing
Medium gap

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

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

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

License-exempt room and board
Large gap

Hotel and Motel stays
Small gap

Non-congregate interim housing models
Small gap

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

Recuperative Care
No gap

Short-Term Post-Hospitalization housing
No gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Not applicable

Peer Respite
Small gap

Permanent rental subsidies
Large gap

Housing supportive services
No gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
Access to housing vouchers are an integral and necessary component to both maintaining and expanding access to housing for BHSA eligible individuals. The local Regional Housing Authority has announced that vouchers will not be open/expanded in the 2026 calendar year. The county utilizes both Encampment

Resolution Funds (ERF) and Behavioral Health Bridge Housing (BHBH) funds to provide emergency, transitional, and rental assistance to BHSA eligible individuals who are experiencing homelessness. ERF funds also provide for a landlord liaison team who has demonstrated success with increasing housing inventory by bringing private landlords into master leasing agreements for BH Housing, as well as navigating individual into housing through housing readiness activities. BHBH funds have been utilized for capital investments to purchase housing, increasing housing inventory. This housing currently serves as transitional housing units and will be transitioned to permanent supportive housing units following the close of the grant period. BHBH funding will sunset in June 2027 and ERF funding will sunset in April 20208. Additionally, the local housing continuum of care relies heavily on the Coordinated Entry System (CES) and the Homeless Management Integration System (HMIS) both as an access/entry point into housing, as well as a data management and sharing platform for local housing resources for unhoused BHSA eligible populations. As the centralized point for entry into housing for those who are unhoused, the county recognizes and emphasizes the importance of accurate data entry, up to date information, and robust data reporting capacity of the local HMIS database. The county actively pursues grants to increase the availability of housing, and has been awarded a HomeKey grant to add an additional 24 beds of permanent supportive housing in FY 2026/27. The county currently funds a diversion house with supportive services for individuals with behavioral health needs, primarily funded through a Department of State Hospitals grant. The county currently funds and plans to continue funding for 97 Recovery Residence beds for individuals with substance use disorders, primarily funded through SUBG. Additionally, the county has, in partnership with several local organizations, co-funded a one-year pilot navigation center project in the Town of Truckee for overnight shelter (10 beds) and interim housing beds (6 beds) for those experiencing homelessness in the region. In the coming year, the county will explore pathways for sustainability and additional funding to sustain the pilot if deemed successful.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
The county works diligently to capture and utilize appropriate and available funding sources to ensure that we are maximizing housing services locally for BHSA eligible individuals. This includes advocating for and utilizing local HUD Voucher allocations; referring to and utilizing CalAIM funding/referrals within the housing trio of services when an individual meets eligibility; pursuing and utilizing grant funding to expand emergency, transitional, and permanent housing options through funding streams such as Encampment Resolution Funds, Behavioral Health Bridge Housing, Behavioral Health Capital Investment Project funds, and HomeKey+ infrastructure funds. Additionally, the county utilizes funding streams such as from the Department of State Hospitals to support housing for justice involved individuals who otherwise may not be able to secure housing due barriers surrounding background checks. BHSA funds will be utilized as a funding source of last resort, to support Permanent Supportive Housing (PSH), where other funding sources are not available.

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

Nevada County Behavioral Health has worked closely with the Board of Supervisors to educate and highlight the importance of a robust and multi-layered housing network within the local BH continuum of care to improve successful outcomes for those within our system of care. This focus has helped to create a system where the local political decision makers understand the need and advocate alongside behavioral health in the pursuit and acquisition of expanding local housing resources. As a behavioral health system, the county believes in the importance of quality care coordination and multi-layered housing support plans to support acquisition and retention of housing units. In alignment with this philosophy, the county works to ensure that there are appropriate touchpoints at each intersection point along the path from unsheltered homelessness into permanent housing. This includes street outreach teams and low barrier emergency sheltering options; transitional housing with comprehensive case management supports including MH and SUD screening and treatment support as appropriate; housing liaison services to navigate access to permanent housing; and post-housing case management support. These services are provided through the lens of advocacy for and supporting client engagement in mental health and substance use treatment services throughout their housing journey. Individuals placed in permanent supportive housing are usually connected with county or contracted behavioral health or FSP services, and include a housing plan, supportive services, life skills development, medication delivery, and other necessary supports to retain housing placements.

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)?

Nevada County Behavioral Health has an internal housing case manager who provides a focus on navigating individuals within our system of care who are experiencing homelessness into housing. Referrals to the NCBH housing case manager are made internally via other treatment team staff familiar with the individual, or directly through the coordinated entry system through the NCBH PSH project in HMIS. In additional to the housing case manager, NCBH contracts with a housing provider who support with acquisition of housing, project management for construction and housing rehabilitation projects, property management, and case management in select housing units within their purview. The county's full service partnership provider has additional housing units that they oversee as a service provider, in addition to providing more intensive case management services to individuals residing in those units. The county has worked to diversity the types of permanent supportive housing opportunities and levels of care within housing units that are available within our housing continuum of care. This allows for housing stability with appropriate supports to meet individual needs. Case managers are able to work with individuals on developing life and housing readiness skills, tailored to meet individual's needs, as they work toward lower levels of care within the housing continuum as appropriate. Lastly the county provides rental assistance for

individuals who are not voucher-eligible in order for them to secure and maintain housing until a voucher becomes available.

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

Housing and housing interventions are an integral part of the behavioral health system of care. County behavioral health works closely with our housing provider and our Full-Service Partnership provider to support access to clinical and behavioral health care for individuals within our housing system of care. The county facilities multi-disciplinary team meetings to collaborate and discuss individuals within our housing units, with the goal of continuity of care across systems of care. The NCBH Adult Behavioral Health, Substance Use Treatment Team, Homeless Outreach and Medical Engagement Team, and housing providers all engage in case conferencing effort to managed and discuss the multi-layered needs of BHSA eligible housing residents. The county also facilitates monthly contractor meetings with these providers to discuss broader system level pathways and practices to ensure access to care.

Eligible Populations

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

The county utilizes the local coordinated entry system as a point of entry for housing services. The coordinated entry list, also known as the "By Name List", is managed by the Continuum of Care (CoC) and accessed through our local 211 operator. While the county has direct access to the by name list, which indicates individuals in need of housing including chronic homeless status and a vulnerability index score, the county also has a distinctive “Permanent Supportive Housing (PSH) Housing Project” within the HMIS system that 211 can directly refer individuals to. This referral pathway allows for a simple referral pathway with direct access to the behavioral health housing liaison. In addition to the By Name List (BNL) and PSH program referrals, behavioral health staff meet to review the by name list to identify individuals within the SMHS and DMC-ODS systems of care in need of housing placement. Once a referral has been identified, the county works to gather documentation pertaining to housing readiness, to ensure that when units of housing are available, there are appropriate referrals ready for the housing unit.

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

Yes

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

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

Through its community planning process, Nevada County conducted focus groups with families of youth mental health and FSP participants and the Stepping Up workgroup which includes various youth criminal justice partners including Nevada County Probation and Nevada County Sheriff's office. Bright Futures for Youth (BFFY)was also a focus group participant. BFFY is a community-based organization that offers the SAFE housing focused program for youth experiencing housing insecurity. Focus groups reviewed population health data including juvenile arrest rates and provided feedback on strengths and gaps.

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

Through its community planning process, Nevada County conducted a key informant interview with a representative from Nevada County Pride, a social network of gay, lesbian, bisexual, queer, and transgender persons, and their allies, who celebrate and support the LGBTQ+ community in western Nevada County, California, including Grass Valley and Nevada City. Additionally, Nevada County conducted focus groups with providers of services to LGBTQ+ youth, including Bright Futures for Youth, Nevada County Behavioral Health staff, Nevada County Superintendent of Schools, Tahoe Truckee Unified School District, Stanford Sierra Youth and Families, and Victor Community Support Services.

In the child welfare system

Through its community planning process, Nevada County conducted focus groups with families of youth mental health and FSP participants, including families with child welfare involvement. Nevada County also conducted focus groups with organizations that partner closely with child welfare through multidisciplinary efforts, including Nevada County Behavioral Health staff, Stanford Sierra Youth and Families, Victor Community Support Services, and Nevada County Child Welfare itself.

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

Older adults

Through its community planning process, Nevada County conducted several focus groups with representation from older adults and/or providers serving older adults, including the Mental Health and Substance Use Advisory Board, Agency 4 Area on Aging, Turning Point, FREED, Nevada County Public Health, Nevada County Adult Services, and Gold Country Community Services. Nevada county also conducted a focus group with SPIRIT Center, the day resource center for individuals experiencing

homelessness. Demographic data from the local Point in Time (PIT) count was reviewed for observable trends and age distribution of individuals experiencing homelessness, as well as age distribution data related to individuals currently engaged in interim housing programs such as BHBH.

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

Through its community planning process, Nevada County conducted a focus group with the Stepping Up workgroup which includes various youth criminal justice partners including Nevada County Probation, Nevada County Sheriff's office, Nevada County Courts, Nevada County District Attorney, and the Nevada County Public Defender. Nevada County Behavioral Health also obtained feedback from co-responder law enforcement teams, which pair a trained mental health crisis clinician with a Nevada County Sheriff's Officer. Focus groups reviewed population health data including arrest rates and provided feedback on strengths and gaps. In order to better understand the need locally, the county reviewed available data within our systems of care (diversion courts, recovery residences, interim housing programs, etc.), to better understand the overlap and prevalence of individuals experiencing sheltered and unsheltered homeless, and justice involvement.

In underserved communities

Through its community planning process, Nevada County conducted a key informant interview with a representative from Nevada County Pride, a social network of gay, lesbian, bisexual, queer, and transgender persons, and their allies, who celebrate and support the LGBTQ+ community in western Nevada County, California. Additionally, Nevada County conducted key informant interviews with a representative from the Nisenan Tribe, Alta Regional Centers, and the Homeless Resource Council of the Sierras, to better understand the needs of these underserved communities locally.

Local Housing System Engagement

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

The county will continue to utilize partnerships and funding associated with the local CoC and the coordinated entry system to ensure that the community and local providers have a streamlined referral and coordinated referral system into housing options. The county and CoC partner to create a joint strategic plan which prioritizes access and continuity of care for BHSA eligible individuals who are unhoused. This strategic plan prioritizes local need, and allows for joint application for funding opportunities, creating a more cohesive local housing system.

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

Local CoC

The county holds a seat on the local CoC board and attends quarterly board meetings for the CoC. This allows for the county to advocate at the CoC level for cross collaboration between agencies related to alignment with the strategic plan, and in order to maximize efficacy and cohesion of the local supportive housing continuum. Additionally, the county provides funding to the CoC for direct operations. The County coordinates regularly with the lead HMIS administrator. These coordination efforts largely surround the coordinated entry system by name list and collateral program entry/exits within HMIS, working to ensure timely and accurate data through regular QA review. HMIS reports, including the by name list and program enrollments, are reviewed collaboratively with the HMIS administrator and partnering ECM and CS providers serving the unhoused population. These meetings are used to discuss and refine collaborative workflows as needed, review reports for data quality, and review client level data from the by name list again upcoming open housing units. The county is contracted with a number of these local agencies for housing support and navigation services, including a provider for PSH development.

Public Housing Agency

The Regional Housing Authority (RHA) serves 4 local counties as part of the Joint Powers of Authority. The county coordinates and advocates with the RHA for local housing voucher allocations.

MCPs

The county works closely with the singular MCP serving Nevada County. This working relationship has deepened, as the county has been working to onboard as a Transitional Rent provider through the MCP. The county participated in the Northern California CalAIM collaborative, of which the MCPs are also participants. The county and MCP have ad hoc meetings to discuss needs within the local behavioral health continuum of care, as it intersects with the MCPs roles and responsibilities. The county has an internal ECM team who provides homeless outreach. Coordination efforts are consistent and ongoing including submission of individualized care plans for ECM member to the MCP, monthly data sharing related to member enrolment, referrals, and invoicing through the MCP's SFTP. The county has access to the MCPs provider portal, through which information can be gathered related to a member's benefits, and treatment authorization requests can be submitted.

ECM and Community Supports Providers
The county has an internal ECM team with a focus on providing case management services to individuals who are unhoused and experiencing co-occurring SMI/SUD concerns. The county participates in CalAIM collaborative efforts such as the NorCal PATH Collaborative, which provides a space for CalAIM providers to come together to share learnings and network. This collaborative maintains a directly of CalAIM providers as a resource. Additionally, the county contracts directly with local Community Supports Providers within the housing trio of services, working closely with these providers to provide continuity of care within the both the housing and case management continuums of care.

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

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?
The county received HomeKey+ funding which has been utilized to purchase and rehabilitate four scattered site housing units and a 16 unit motel, that is currently being utilized for interim housing through BHBH. The county is working collaboratively with our housing provider to rehabilitate these units in preparation for occupancy within the next year. Once construction is complete and the units have their certificate of occupancy, the units will be converted into Permanent Supportive Housing (PSH). Services for these PSH units will be provided by NCBH or FSP case management staff and the county's housing provider. Referral into these units will come from the coordinated entry system, prioritizing individuals who are chronically homeless with high vulnerability index score.

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

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?
The county will pair HHAP dollars with BHSA dollars to increase support for permanent supportive housing. The joint application for HHAP 6 funding with the CoC is still pending, and a dollar amount has not yet been allocated local, however the county anticipates receiving HHAP 6 funding dollars.

BHSA Housing Interventions Implementation

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

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

Is the county providing this intervention?
Yes

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

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
200

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
103

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
97

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
The county is utilizing the available data identifying the total number of units available in each setting type during FY 25/26 and the average length of stay of participants (turnover rate) to estimate the total number of individuals served in each setting type annually. Additionally, the county is using number of emergency hotel/motel placements for BHSA eligible individuals in FY 24/25.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Time Limited Interim Settings: Hotel and motel stays

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The county will utilize BHSA funds to provide rental assistance to place and maintain BHSA eligible individual in non-time limited permanent supportive housing under a housing first model. The county will utilize existing project based and master leased housing models to provide permanent housing with supportive services (funded through alternative funding to BHSA rental subsidy) such as case coordination and management, life skills development classes, recovery focused groups, medication management, and access to clinical and psychiatric services as appropriate. BHSA rental assistance funds will be utilized in cases where a housing subsidy voucher is not currently available to support the individual in maintaining permanent housing. The county will work with their housing and FSP providers for coordination of this benefit. Additionally, BHSA Housing Interventions will be used to fund emergency hotel or motel stays for BHSA eligible individuals.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?
Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
The county actively seeks grant opportunities that allow for infrastructure procurement and development to grow the local portfolio of housing units available for BHSA eligible individuals. The county contracts with housing providers who procure and rehabilitate housing units. The landlord liaison team and landlord mitigation funds have been a contributor to the success of the local growing behavioral health housing inventory, as they proactivity seek out, engage, and incentivize landlords to participate in behavioral health housing efforts. The growth of behavioral health housing inventory has also included assessment and a focus on ensuring that the county has a multi-layered housing portfolio (emergency, interim, recovery residences, PSH, congregate and non-congregate settings), to help ensure that we are able to meet the diverse needs of the individuals we serve. This multi-layered housing approach allows us to support a

step-down housing pathway that promotes goal setting and opportunities for independence alongside success for each individual. Additionally, the county maintains an up to date and detailed list of housing units within our portfolio. The county works closely with contracted housing providing to understand the current housing inventory, including what units will be coming available. The NCBH Housing Liaison works to maintain a list of individuals who are document ready to refer to open housing units for when a unit becomes available. This list is developed directly from the coordinated entry systems by name list, with the Housing Navigator working proactively to perform outreach and support BHSA eligible individuals on the by name list to become document ready. NCBH has also created strategic relationships with local hotels and motels to accommodate emergency stays for BHSA eligible individuals.

Total number of units funded with BHSA Housing Interventions per year
127

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

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
127

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The county will utilize BHSA funds to provide operating subsidies for existing BHSA Permanent Supportive Housing Programs in order to support the costs associated with the day-to-day physical operation of the housing projects. These costs include basic maintenance and repair to the units, property taxes and insurance, costs associate with the contracted property manager, and housing incidentals such as furnishing, appliance replacement, and a spare basic needs supply kit for program residents.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing

Will this be a scattered site initiative?
Yes

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
127

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

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

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
While the county is not using BHSA funding to provide this intervention, this intervention is being provided within the county's BH continuum of care through an established contracted provider utilizing Encampment Resolution Funds (ERF). This landlord liaison team has been in operations for over one year and had been very successful at increasing housing inventory for BHSA eligible individuals through landlord engagement. This strategy has allowed for a pathway from interim housing (through BHBH) to permanent housing units secured by the landlord team.

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

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
The county plans to utilized BHSA funds for rental assistance and operating expenses in relation to Permanent Supportive Housing units within our system of care. The county plans to use alternative funding sources, particularly those that are time limited grant funding opportunities, for participant assistance related expenses such as paying fees associated with securing housing, storage fees, other move in costs, and rent and utility arrears needed to support individuals in maintaining housing.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
While the county is not using BHSA funding to provide this intervention, this intervention is being provided within the county's BH continuum of care through a robust CalAIM network or community supports providers.

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
865

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The county will use BHSA Housing Outreach and Engagement funds to support funding gaps to support the existing NCBH Homeless Outreach and Medical Engagement (HOME) Team. The HOME team provides

outreach and engagement services to unsheltered BHSA Eligible individuals, providing a focus on individuals with co-occurring (SMI/SUD) conditions, who historically have been resistant to engage in behavioral health continuum of care. The team works to locate, identify, and build trusting relationship with this cohort of individuals, serving as a "whatever it takes" model of engagement. The team provides immediate intervention with support for basic needs, and connections to available resources, with the overarching goal of connecting individuals to housing first housing opportunities and behavioral health assessment and services. The team is an integral part of the NCBH continuum of care and works closely with SUD providers, therapists, housing providers, and local justice providers (jail, law enforcement, forensic team) to coordinate care and wholistically meet the needs of the individuals they serve. BHSA Homeless Outreach dollars will also be used to support Commons Resource Center operations, operated by SPIRIT, who provides peer support day services to those experiencing homelessness including outreach and engagement, linkage to services, and peer led recovery focused support groups to BHSA eligible individuals experiencing unsheltered homelessness. Finally, funds will support an Adult Homeless Outreach program that connect individuals to behavioral health care, housing resources, and supportive services. The program is designed to meet people where they are at, whether in encampments, on the streets, or in other unsheltered settings – guiding them toward stability through individualized planning and wraparound support. A full-time Outreach Case Manager (OCM) will lead these efforts by building trust with individuals experiencing homelessness and providing direct referrals to mental health and medical services. This position will also encourage clients to utilize emergency shelter, housing navigation services, benefit assistance, and transportation resources, while acting as an advocate for other needed services such as substance use treatment and employment programs. The OCM will participate in multi-disciplinary team meetings, including the Homeless Outreach Team (HOT), to ensure coordination across the continuum of care. All services and referrals will be documented in the Homeless Management Information System (HMIS) for tracking and evaluation.

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

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?

No

Please explain why the county is not providing this intervention

While the county is not using BHSA funding to provide this intervention, this intervention is being provided within the county's BH continuum of care through alternative funding streams. Over the past 5 years, the county has received an infusion of grant funds for the purpose of capital development projects. These grant funds have been used to grow the county's infrastructure for housing solutions and opportunities for individuals experiencing or at risk of experiencing homelessness who have behavioral health and/or substance use needs. This growth within the housing system has included additional interim housing

capacity through non-congregate sheltering in motels; the purchase and maintenance of housing focused on individuals who are justice involved and part of court diversion programs; and increased permanent supportive housing beds through master leasing and infrastructure purchases. Over the past 6 years the county has grown the available bed within the scope of our BHSA funded permanent supportive housing units by over 300%, with the 2019 Housing Inventory Count (HIC) count at 20 beds of PSH and the 2024 HIC count at 63 beds of PSH. Our current internal count of BHSA funded PSH beds in 2026 is 94, with an estimated additional 24 units coming online within the next year through additional scattered site housing purchased through HomeKey+ funds. In addition to growing the number of PSH bed available, the options available for interim housing has increased substantially over the past few years through funding such as HomeKey, AARPA, BHCIP, BHBH, and ERF. Currently there is approximately 50 interim beds available through non-BHSA funded sources, not including recovery residence beds which provide an addition 97 beds of non-BHSA funded transitional housing (Recovery Residences) for those moving through substance use treatment. Much of this growth has been a direct result of capital development projects secured through grant funding and with sustained operations through non-BHSA funding streams.

Other Housing Interventions

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

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

Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
At this time, the county does not plan to use BHSA funds to support the continuing of BHBH housing programs. The continuation of these programs will be sustained through the one time infusion of infrastructure dollars to secure the units long term, the use of housing vouchers to provide rental subsidy as available, and the leveraging of CalAIM support services for the provision of case management services within the housing units.

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

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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

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

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2026

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?
The county will utilize the existing referral pathways to refer individuals to housing related community supports covered by the Managed Care Plan. The county will utilize the MCPs provider portal to access information related to an individual's eligibility for services through the MCP. If it has been identified that an individual who may be eligible for housing related community supports is not currently enrolled in those supports and would like to be, the county will refer those individuals to the local provider of those services to ensure a warm hand off. The county will serve as a transitional rent provider for BHSA eligible individuals, and will implement an internal workflow to ensure each person is screened for transitional rent eligibility as housing units become available.

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
The majority of housing providers are participating in a learning collaborative funded by NCBH BHSA Innovation project dollars to explore expansions in contracts with the MCP for housing-related Community Supports. NCBH is helping to facilitate conversations and/or contract expansions with the MCP, including housing-related Community Supports.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
Yes

Please describe the county behavioral health system's coordination efforts to align network development
Nevada County Behavioral Health (NCBH) has ongoing conversations with its housing providers regarding contracting with MCPs for housing-related Community Supports. The majority of housing providers are participating in a learning collaborative funded by NCBH BHSA Innovation project dollars to explore expansions in contracts with the MCP for housing-related Community Supports. NCBH is also asking contractors to explain how their services are not duplicative with housing-related Community Supports in the upcoming fiscal year's contract negotiations, and are asking contractors to declare any revenue received from housing-related Community Supports within the scope of their contract.

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?
Nevada County Behavioral Health collaborates closely with local housing providers including those who are contracted with the MCP for housing services. In most cases, NCBH is also contracted with those providers, and works to create clear referral pathways to county behavioral health services to ensure continuity of care, which has strengthened through the implementation of the Behavioral Health Access Team which can perform walk-in and field-based assessments.

Flexible Housing Subsidy Pools

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

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

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
No

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
The county behavioral health system does not plan to launch or scale a flex pool at this time. After reviewing the framework of the Flex Pool model and local funding availability to contribute to a Flex Pool, the county decided not to pursue the model at this time. The county will reevaluate this model should local

fiscal conditions change.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

Does the county's plan include the development of innovative programs or pilots?

No

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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

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

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

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

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

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
No

If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner
For all BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System, NCBH plans to include contract language to address provider qualifications, compliance with nondiscrimination requirements, and delivery of services in a culturally competent manner.

Build Workforce to Address Statewide Behavioral Health Goals

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

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
27

Upload any data source(s) used to determine vacancy rate
FY 24-25 Vacancy Rates.xlsx

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Mental Health Rehabilitation Specialist
Nurse practitioner
Psychiatrist
Substance Use Disorder Counselor
Other qualified provider

Please describe any other key workforce gaps in the county
Nevada County has experienced challenges in hiring qualified administrative staff, particularly those with combined Quality Assurance and Clinical expertise.

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)?
Nevada County Behavioral Health (NCBH) is currently participating in a Performance Improvement Plan (PIP) to increase the number of clients receiving peer support services. As part of this effort, NCBH is looking to increase peer support staffing, with a specific focus on embedding peers in our crisis system of care. Additionally, NCBH anticipates needing significantly more administrative support in the realms of data analysis, quality assurance, and billing to adequately assess BHT and BH Connect measures. Nevada County conducted a Request for Proposal process for all FY 26/27 services including new requirements under BHT and BH-CONNECT, and all necessary staffing changes and training needs have been incorporated into contracts and budgets accordingly. Through ongoing learnings through the Centers of Excellence on fidelity to the various Evidence Based Practice requirements, Nevada County will evaluate in partnership with its contracted providers if there are future needs for enhanced staffing or training, and will also work with the Centers of Excellence to understand rural accommodations for various staffing models. Additionally, Nevada County plans to provide contracted providers with incentive dollars to assist with the cost of training, fidelity monitoring, and Center of Excellence engagement for at least Fiscal Year 2026/2027.

Address Workforce Gaps

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

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
NCBH plans to encourage providers to apply for qualifying BH CONNECT workforce programs. Nevada County Behavioral Health has a designated Workforce Education and Training lead (Senior Administrative Analyst) who is monitoring for all upcoming BH CONNECT workforce opportunities, and sends email notifications to all behavioral health staff including contracted providers about upcoming opportunities such as new application periods.

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

Please explain any actions or activities the county is engaging in to leverage the program
NCBH plans to encourage providers to apply for qualifying BH CONNECT workforce programs. NCBH plans to encourage providers to apply for qualifying BH CONNECT workforce programs. Nevada County Behavioral Health has a designated Workforce Education and Training lead (Senior Administrative Analyst) who is monitoring for all upcoming BH CONNECT workforce opportunities, and sends email notifications to all behavioral health staff including contracted providers about upcoming opportunities such as new application periods.

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

Please explain any actions or activities the county is engaging in to leverage the program
Nevada County Behavioral Health has a designated Workforce Education and Training lead (Senior Administrative Analyst) who is monitoring for all upcoming BH CONNECT workforce opportunities. This Analyst will identify opportunities for participation in the Behavioral Health Recruitment and Retention program and will identify opportunities for County application and/or Contractor applications, and will disseminate information about this program to necessary organizations.

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

Please explain any actions or activities the county is engaging in to leverage the program
NCBH plans to encourage providers to apply for qualifying BH CONNECT workforce programs. Nevada County Behavioral Health has a designated Workforce Education and Training lead (Senior Administrative Analyst) who is monitoring for all upcoming BH CONNECT workforce opportunities, and sends email notifications to all behavioral health staff including contracted providers about upcoming opportunities such as new application periods.

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

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
NCBH continues to offer differential pay for bilingual clinical staff.

Budget and Prudent Reserve

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

Budget and Prudent Reserve

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

Please upload the completed budget template
Integrated-Plan-Budget-Template_v3 04.06.26.xlsx

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

Behavioral Health Services and Supports (BHSS)
Not Applicable

Full Service Partnership (FSP)
Not Applicable

Housing Interventions
Not Applicable

Enter date of last prudent reserve assessment
3/31/2026

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

BHSS
Not Applicable

FSP
Not Applicable

Housing Interventions
Not Applicable

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 69,213.90	$ 71,201.97	$ 70,198.90	$ 115,356.50	$ 118,669.94	$ 116,998.16	75.00	125.00
Early Intervention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Outpatient Services	☑	$ 5,308,731.04	$ 5,599,681.06	$ 5,844,842.94	$ 118,512.67	$ 124,827.73	$ 130,250.48	950	30.00
Intensive Outpatient Services	☑	$ 221,197.13	$ 233,320.04	$ 243,535.12	$ 2,418.63	$ 2,547.50	$ 2,658.17	43	1.00
Crisis and Field-Based Services	☑	$ 126,538.70	$ 132,067.41	$ 136,163.15	$ -	$ -	$ -	7	0.00
Residential Treatment Services	☑	$ 3,793,667.61	$ 3,959,420.07	$ 4,082,211.44	$ 37,248.54	$ 38,875.99	$ 40,081.63	342	5.00
Inpatient Services	☑	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Mental Health (MH) Services									
Primary Prevention Services	☑	$ 3,375.32	$ 3,694.07	$ 3,973.16	$ 365,894.96	$ 385,398.04	$ 400,559.33	50	100
Early Intervention Services	☑	$ 477,657.57	$ 494,986.96	$ 506,493.19	$ 1,234,076.18	$ 1,105,526.84	$ 1,140,458.80	504	1906
Outpatient and Intensive Outpatient Services	☑	$ 12,041,511.22	$ 12,892,111.66	$ 13,597,566.67	$ 10,275,405.59	$ 10,914,461.62	$ 11,432,007.62	1486	1057.72
Crisis Services	☑	$ 5,692,109.43	$ 5,936,164.17	$ 6,112,661.03	$ 992,427.83	$ 1,035,321.03	$ 1,066,436.20	2592	551.37
Residential Treatment Services	☑	$ 1,512,918.79	$ 1,576,635.38	$ 1,622,393.01	$ 143,375.64	$ 149,811.29	$ 154,539.89	33	4
Hospital and Acute Services	☑	$ 4,883,070.68	$ 5,084,244.89	$ 5,249,857.78	$ 364,694.30	$ 378,845.99	$ 392,197.94	292	41
Subacute and Long-Term Care Services	☑	$ 843,472.10	$ 880,143.05	$ 906,804.24	$ -	$ -	$ -	5	0
Housing Services (MH + SUD)									
Housing Services	☑	$ 10,964,139.00	$ 8,152,742.54	$ 8,465,851.60	$ 158,200.24	$ 314,375.49	$ 325,881.56	1486	25.09
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 45,937,602.49	$ 45,016,413.28	$ 46,842,552.23	$ 13,807,611.07	$ 14,568,661.47	$ 15,202,069.78	7865.01	3846.18

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

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

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures (Year One)**	**Total Projected Expenditures (Year Two)**	**Total Projected Expenditures (Year Three)**
Capital Infrastructure Activities	$ 20,133,035.52	$ -	$ -
Workforce Investment Activities	$ 209,751.94	$ 65,784.13	$ 67,972.40
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 5,153,045.42	$ 5,184,178.82	$ 5,344,905.57
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 756,962.31	$ 819,488.21	$ 873,001.50
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 26,252,795.18	$ 6,069,451.17	$ 6,285,879.46

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 8,910,470.42	$ 9,075,185.05	$ 9,517,235.10
1991 Realignment (Bronzan-McCorquodale Act)	$ 3,435,398.03	$ 3,967,291.83	$ 4,080,430.23
2011 Realignment (Public Safety Realignment)	$ 7,341,555.62	$ 6,232,562.08	$ 7,959,304.43
State General Fund	$ 2,496,147.99	$ 2,708,565.54	$ 2,759,327.81
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 35,028,161.00	$ 38,008,992.32	$ 38,721,333.45
Projects for Assistance in Transition from Homelessness (PATH)	$ 151,421.34	$ 154,327.00	$ 154,327.00
Community Mental Health Block Grant (MHBG)	$ 241,958.00	$ 241,958.00	$ 241,958.00
Substance Use Block Grant (SUBG)	$ 696,195.00	$ 707,265.91	$ 660,343.10
Commercial Insurance	$ 225,072.00	$ 225,072.00	$ 225,072.00
County General Fund	$ 30,893.00	$ 30,893.00	$ 30,893.00
Opioid Settlement Funds	$ 100,000.00	$ -	$ -
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 213,848.81	$ 213,848.81	$ 227,376.00
Other state funding (including DSH funding)	$ 23,288,143.54	$ 1,237,263.45	$ 902,763.15
Other county mental health or SUD funding	$ 3,707,161.99	$ 2,851,300.93	$ 2,850,138.20
Other foundation funding	$ 131,582.00	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 85,998,008.74	$ 65,654,525.92	$ 68,330,501.47
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 59,745,213.56	$ 59,585,074.76	$ 62,044,622.01
Auto-validation: Table 2: Other County Expenditures	$ 26,252,795.18	$ 6,069,451.17	$ 6,285,879.46

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 38-40: input your county's base BHSA funding allocation by component and year.
Rows 43-54: this section will be auto-populated from the sections below it.
Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.
Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.
Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.
Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.
Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.
Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.
Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.
Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.
Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.
Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.
Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.
Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."
Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."
Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."
Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.
Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."
Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.
Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.
Row 133: enter the dollar amount of prior year prudent reserve ending balance
Row 134: enter the prudent reserve maximum for your county.
Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**
Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.
Row 139: the total transferred excess prudent reserve is auto-populated.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers

	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 2,515,728.00	$ 2,935,016.00	$ 2,935,016.00	$ 8,385,760.00
Year Two Component Allocation (dollars)	$ 2,657,579.00	$ 3,100,509.00	$ 3,100,509.00	$ 8,858,597.00
Year Three Component Allocation (dollars)	$ 2,820,006.00	$ 3,290,007.00	$ 3,290,007.00	$ 9,400,020.00

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)	$ 2,515,728.00	$ 2,935,016.00	$ 2,935,016.00	$ 8,385,760.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 1,663,445.00	$ 1,663,444.00	$ 3,326,889.00
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)	$ 2,657,579.00	$ 3,100,509.00	$ 3,100,509.00	$ 8,858,597.00

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)	$ 2,820,006.00	$ 3,290,007.00	$ 3,290,007.00	$ 9,400,020.00

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)

Base Component (Year One)	Housing Intervention Percentage (Year One)	Housing Intervention Funds (Year One)
Base Percentage and Funding	30%	$ 2,515,728.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 2,515,728.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 2,935,016.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 2,935,016.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 2,935,016.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 2,935,016.00

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%	$ 2,657,579.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 2,657,579.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 3,100,509.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 3,100,509.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 3,100,509.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 3,100,509.00

Funding Transfers (Year Two)

	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)

Base Component	Housing Intervention Percentage (Year Three)	Housing Intervention Funds (Year Three)
Base Percentage and Funding	30%	$ 2,820,006.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 2,820,006.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 3,290,007.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 3,290,007.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$ 3,290,007.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 3,290,007.00

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	$ 1,471,829.00	$ -	$ 1,471,829.00	$ -
PEI	$ 866,891.00	$ -	$ 191,616.00	$ 675,275.00
Encumbered INN	$ 957,136.00	$ -	$ -	$ 957,136.00
Unencumbered INN	$ -	$ -	$ -	$ -
WET	$ 31,033.00			$ 31,033.00
CFTN	$ -			$ -
Total (auto-populated)	$ 3,326,889.00	$ -	$ 1,663,445.00	$ 1,663,444.00

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 1,111,502.00
Local Prudent Reserve Maximum (2)	$ 1,881,036.71
Excess Prudent Reserve Funding that must be transferred	**$ (769,534.71)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions
Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for other non-BHSA funding sources in Tab Five.
Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers t
Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-popula the sum of rows 40-42 to account for total funding
Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you wi transferring excess PR funds to Housing Interventions please report them her
Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each ye
Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to pl individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligit individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Re through their Medi-Cal MCP
Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Manag Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all ot funding sources excluding BHSA in columns F, G, and k
Row 63: input expenditures for BHSA-funded innovation pilots or project
Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the si-allocations above
Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Po
Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reser
Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Cc
Row 70: the overall total of Housing Intervention expenditures will be auto-populat from rows 65, 67, and 69.
Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless populat This amount should equal 50% of Housing Interventions component allocatio
Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substar use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 7
Row 75: the proportion of funds dedicated to capital development will be auto-populat.
Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populat.
Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populate
Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component servic
Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each y
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable lav regulations, and guidance, including the BHSA County Policy Manu
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, includ requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BH funding and another funding source, such as Medi-Cal payment, commercial payment, et

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)	$ 2,515,728.00	$ 2,657,579.00	$ 2,820,006.00
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)	$ 2,515,728.00	$ 2,657,579.00	$ 2,820,006.00

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	$ 352,632.7(	$ 368,075.7(	$ 362,910.1(	$ 18,393.0(	$ 213,848.81	$ 227,376.0(
Operating Subsidies	$ 506,177.2(	$ 709,063.7(	$ 730,595.2(	$ 502,330.0(	$ 524,796.94	$ 540,698.9(
Bundled Rental and Operating Subsidies	$ 1,008,288.72	$ 1,039,325.59	$ 1,092,439.65	$ 1,287,564.18	$ 1,360,364.27	$ 1,382,591.91
% of Rental and Operating Subsidies Administered through Flex Pool:	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 378,943.0(	$ 256,222.0(	$ 331,756.0(	$ 151,994.5(	$ 282,654.7(	$ 208,409.2(
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pool:	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ 169,056.92	$ 178,589.31	$ 189,504.40	$ 541,579.97	$ 563,502.78	$ 575,101.63
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 2,415,098.5(	$ 2,551,276.41	$ 2,707,205.42	$ 2,501,861.72	$ 2,945,167.59	$ 2,934,177.71

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	$ 100,629.12	$ 106,303.16	$ 112,800.24
Total Housing Interventions Expenditures (auto-populated)	$ 2,515,727.70	$ 2,657,579.56	$ 2,820,005.66
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 1,357,706.77	$ 1,502,851.07	$ 1,573,101.16
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 176,208.50	$ 119,143.23	$ 154,266.54
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)	0.0%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	54.0%	56.5%	55.8%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated	6.7%	6.7%	6.7%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	375	375	375
Eligible Adults/Older Adults	1486	1207	1207
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

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

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.

Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.

Rows 31-40: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.

Row 39: input expenditures for BHSA-funded innovation pilots or projects.

Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub -allocations above.

Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.

Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.

Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding	Total Full Service Partnership (FSP) Funding	Total Full Service Partnership (FSP) Funding
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 2,935,016.00	$ 3,100,509.00	$ 3,290,007.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 2,935,016.00	$ 3,100,509.00	$ 3,290,007.00

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)	$ 324,854.48	$ 343,171.61	$ 364,145.71	$ 588,142.53	$ 614,075.33	$ 633,710.75	$ 136,098.34	$ 140,240.00	$ 135,167.70
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 81,213.62	$ 85,792.90	$ 91,036.43	$ 147,035.63	$ 153,518.83	$ 158,427.69	$ 34,024.58	$ 35,060.00	$ 33,791.93
FSP Intensive Case Management	$ 812,136.19	$ 857,929.02	$ 910,364.27	$ 1,470,356.32	$ 1,535,188.34	$ 1,584,276.88	$ 340,245.84	$ 350,599.99	$ 337,919.25
High Fidelity Wraparound	$ 1,436,983.83	$ 1,518,009.10	$ 1,610,787.40	$ 2,336,198.95	$ 2,436,519.45	$ 2,512,658.79	$ 288,795.03	$ 289,777.65	$ 254,826.09
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 162,427.24	$ 171,585.80	$ 182,072.85	$ 294,071.26	$ 307,037.67	$ 316,855.38	$ 68,049.17	$ 70,120.00	$ 67,583.85
Assertive Field-Based Initiation for SUD Treatment Services	$ -	$ -	$ -	$ 1,349,465.14	$ 1,413,973.76	$ 1,460,173.05	$ 1,961,084.72	$ 2,131,934.69	$ 2,281,487.03
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define									
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define									
BHSA Innovative FSP Pilots and Projects									
MHSA INN Projects									
Subtotal (auto-populated)	$ 2,817,615.35	$ 2,976,488.43	$ 3,158,406.66	$ 6,185,269.83	$ 6,460,313.38	$ 6,666,102.53	$ 2,828,297.67	$ 3,017,732.33	$ 3,110,775.85

FSP Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$ 117,400.64	$ 124,020.35	$ 131,600.28
Total Full Service Partnership Expenditures (auto-populated)	$ 2,935,015.98	$ 3,100,508.78	$ 3,290,006.94
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	140	140	140
Eligible Adults/Older Adults	534	534	534
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

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

Instructions
Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.
Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.
Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.
Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.
Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.
Row 45: input expenditures for BHSA-funded innovation pilots or projects.
Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46
Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6, BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.
Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).
Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.
Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.
These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 2,935,016.00	$ 3,100,509.00	$ 3,290,907.00
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)	$ 524,915.00	$ 216,569.00	$ 117,216.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 3,459,931.00	$ 3,317,078.00	$ 3,407,223.00

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)	$ 550,532.97	$ 606,408.19	$ 678,145.11	$ 1,341,398.47	$ 1,399,000.49	$ 1,442,718.17	$ 440,374.55	$ 431,586.62	$ 393,052.66
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 818,023.05	$ 839,314.76	$ 855,938.13	$ 1,291,179.36	$ 1,356,168.46	$ 1,399,145.79	$ 1,787,110.94	$ 1,870,226.98	$ 1,933,784.30
Early Intervention Expenditures	$ 1,517,298.00	$ 1,747,334.40	$ 1,741,538.99	$ 258,519.70	$ 498,405.64	$ 524,285.00	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$ 190,971.68	$ 200,046.53	$ 206,445.53	$ 258,519.70	$ 269,620.99	$ 278,046.44	$ -	$ -	$ -
All Other EI Expenditures	$ 1,326,326.33	$ 1,547,287.88	$ 1,535,093.46	$ -	$ 228,784.65	$ 246,238.59	$ -	$ -	$ -
Outreach and Engagement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 456,676.07	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 3,342,530.10	$ 3,193,057.35	$ 3,275,622.23	$ 2,891,097.53	$ 3,253,574.59	$ 3,366,148.98	$ 2,227,485.49	$ 2,301,813.60	$ 2,326,836.96

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	$ 117,400.64	$ 124,020.35	$ 131,600.28
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 3,459,930.74	$ 3,317,077.70	$ 3,407,222.50

Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 1,036,265.11	$ 1,191,238.25	$ 1,169,227.49

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)	61.4%	62.7%	60.6%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	68.3%	68.2%	67.1%

Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	2227	2257	2257
Eligible Adults/Older Adults	1636	1686	1639

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	$ 31,033.00	$ 31,033.00	$ 31,033.00
Estimated MHSA CF/TN Funds	$ -	$ -	$ -
MHSA "Encumbered" INN	$ 957,136.00	$ 500,459.93	$ 500,459.93

References

1. W&I Code § 5892, subdivision (a)(1)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).

2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.

3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.

4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.

5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

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

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

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

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

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 86,628.77	$ 94,783.17	$ 101,919.45
Total Projected County Integrated Plan Annual Planning Expenditures	$ 86,628.77	$ 94,783.17	$ 101,919.45
New and Ongoing Administrative Costs	$ 173,257.54	$ 189,566.34	$ 203,838.91
Select County Population Size:	Less than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 8,385,760.00	$ 8,858,597.00	$ 9,400,020.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	1.0%	1.1%	1.1%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	1.0%	1.1%	1.1%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

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

Instructions

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

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

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

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

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

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

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 1,111,502.00
Local Prudent Reserve Maximum (1)	$ 1,881,036.71
Excess Prudent Reserve Funds (auto-populated)	$ (769,534.71)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

References
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

Plan Approval and Compliance

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

Behavioral health director certification

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

Please upload the completed Behavioral health director certification template
Behavioral Health Director Certification Template_DRAFT_Signed.pdf

County administrator or designee certification

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

Please upload the completed County administrator or designee certification template
County Administrator or Designee Certification Template_DRAFT_Signed.pdf

Board of supervisor certification

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

Please upload the completed Board of supervisor certification template

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

Data Suppression Notice:

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

NEVADA COUNTY CALIFORNIA | Behavioral Health

BEHAVIORAL HEALTH COMMUNITY NEEDS ASSESSMENT 2025

Assessment Conducted and Prepared By

EVALCORP Measuring What Matters®

TABLE OF CONTENTS

INTRODUCTION

Behavioral Health Services Act

The Behavioral Health Services Act (BHSA), enacted following the approval of Proposition 1 in March 2024, seeks to reform California's approach to mental health and substance use disorder services. This legislation replaces the 2004 Mental Health Services Act (MHSA), expanding its scope to include services for substance use disorders and prioritizing housing interventions for individuals with mental illness and/or substance use disorders who are experiencing homelessness.

Statewide Goals. As part of the implementation of BHSA, known as Behavioral Health Transformation (BHT), the California Department of Health Care Services (DHCS) *has identified 14 statewide behavioral health goals aimed at improving well-being and reducing adverse outcomes. These behavioral health goals will inform state and county planning and prioritization of BHSA resources, and DHCS will continuously assess statewide and county progress toward these goals.*[1] A list of the statewide goals is provided in Appendix 1.

Integrated Plan. *The BHSA requires counties to submit Three-Year Integrated Plans (IPs) for Behavioral Health Services and Outcomes*. The Integrated Plans are intended to provide a *global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA* funds. The Integrated Plans are completed based on a template provided by the DHCS and include programs and strategies for addressing the Statewide Goals.

Community Program Planning Process

Similar to the MHSA, the BHSA requires county behavioral health departments to collaborate *with local stakeholders to develop each element of their Integrated Plan*. *Counties are required to demonstrate a partnership with constituents and stakeholders through a process that includes meaningful stakeholder involvement*. Meaningful stakeholder engagement *requires that counties conduct a community planning process that is open to all interested stakeholders and provides opportunities for stakeholders to voice feedback on key planning decisions*. Examples of meaningful partnerships with stakeholders may include education, listening sessions, town hall meetings, focus groups, surveys, key informant interviews, or other methods.

[1] NOTE: *italicized text* in the Introduction and Methods section is taken verbatim from the BHSA County Policy Manual

Required Stakeholders. Twenty-four distinct stakeholder groups are required for engagement, as well as participation from six additional groups of individuals. These groups are listed in Appendix 2.

The purpose of this report is to summarize the feedback received from stakeholders as part of the Community Program Planning Process for the Integrated Plan covering the three years beginning July 2026 (i.e., starting Fiscal Year 26/27).

METHODS

Data Collection

Stakeholder engagement for the Integrated Plan primarily consisted of data collection, which took place between late August and early November 2025. Data collection methods included 16 focus groups, eight key stakeholder interviews, one survey, and one demographic form. A detailed summary of respondents is provided in the next section (Stakeholders Engaged), and a list organized by required stakeholder categories is provided in Appendix 2.

The primary data source used to create the results in this report was notes collected by human notetakers during the interviews and focus groups. Many quotes in the report are direct quotes that were transcribed by notetakers, while others were reconstructed based on these notes.

Organization of Results

Stakeholder feedback from the focus groups and interviews was organized thematically and is presented in the context of the Statewide Goal or component of the behavioral health continuum of care in which it most directly corresponds. Focus group, interview, and survey questions, for the most part, directly corresponded to one component of the continuum of care. Following the overview of stakeholders engaged, results are presented in the following order:

- Stakeholders Engaged
- Stakeholder Survey Results
- BHSA Goals
- Crisis Services
- Housing
- Severe Mental Illness (SMI)
- Substance Use Disorder (SUD)
- Workforce

Note that the Stakeholder Survey Results are reported separately, with results summarized by question. The interview and focus group results are integrated across the five themes, which are further divided into subthemes (generally, Strengths, Limits of Services, and Recommendations).

STAKEHOLDERS ENGAGED

Focus Groups

Sixteen focus groups were conducted during September through early November 2025. A brief description of the groups conducted is provided in Table 1 below. There was a total of 210 participants across the 16 focus groups.

Table 1. Focus Groups Conducted (N=210)

#	Host Organization/Site	# of Participants	Format	Language
1	Adult Mental Health Consumers in Western County	10	In-person	English
2	Adult Mental Health Consumers in Truckee	3	In-person	English
3	Adult Mental Health and Substance Use Advisory Board	9	In-person	English
4	Youth Consumers' Family Members	8	In-person	English
5	Youth Consumer Providers	3	In-person	English
6	Behavioral Health Providers	28	Virtual	English
7	NCBH All Staff Meeting	47	In-person (staff facilitated)	English
8	Tahoe Truckee Providers	11	In-person	English
9	Youth Early Intervention Providers	3	Virtual	English
10	Criminal Justice Partners	9	Virtual	English
11	Educators in Western County	7	Virtual	English
12	Health Care Providers	17	Virtual	English
13	Spanish Speaking Consumers in Truckee	13	In-person (staff facilitated)	Spanish
14	Spanish Speaking Providers in Truckee	10	In-person	Spanish
15	Unhoused	20	In-person	English
16	Overdose Prevention Coalition	12	In-person (staff facilitated)	English

Focus Group Demographic Form

This section summarizes demographic data for participants who completed a demographic form after participating in a 2025-2026 CPP Nevada County Stakeholder Focus Group. Below is a summary of responses.

Demographic data were analyzed using descriptive statistics. Across the 16 focus groups conducted, a total of 152 out of 210 individuals completed a demographics survey at the conclusion of their participation. This discrepancy is normal, as completing a demographic survey is encouraged but not required. A snapshot of participants' demographic and background characteristics is outlined below and presented in Table 2.

- 66% White or Caucasian, 15% Hispanic or Latino, seven percent multiracial, three percent American Indian or Other Indigenous group, two percent Asian or Asian American/other Pacific Islander, one percent Black or African American, and six percent preferred not to answer.
- 70% female
- 78% of focus group participants were adults between the ages of 25 and 59, followed by older adults (21%), and transitional age youth (1%).
- 84% of focus group participants primarily spoke English at home, 11% spoke Spanish, three percent spoke English and Spanish, and one percent spoke English and Tagalog. One percent preferred not to answer this question.

Table 2. Demographic Data for Individuals Who Completed the Focus Group Demographic Survey (N=152)

Demographics		Percent*
Race N=152	White or Caucasian	66%
	Hispanic or Latino	15%
	Multiracial	7%
	American Indian or other Indigenous Group	3%
	Asian or Asian American/other Pacific Islander	2%
	Black or African American	1%
	Prefer not to answer	6%
Gender N=152	Female	70%
	Male	27%
	Gender Non-conforming/Gender Fluid	1%
	Prefer not to answer	2%
Age Group N=150	Adults (25-59)	78%
	Older Adults (60+)	21%
	Transition Age Youth (TAY, 18-24)	1%
Language Spoken at Home N=151	English	84%
	Spanish	11%
	English and Spanish	3%
	English and Tagalog	1%
	Prefer not to answer	1%

*Column percent was calculated based on valid response rates.

Roles That Focus Group Participants Represented

Table 3 shows that "community member" was the most common role that focus group identified with, followed by "mental health consumer/client" and "mental health service provider (32% each), "family member of a mental health consumer/client"(22%), "Member of a community-based organization" (22%), and "County Employee" (20%). See Table 3 for additional roles indicated applied to focus group participants. Two focus group participants indicated they were criminal justice system partners, and two reported the role of a Judge.

Table 3. Roles that Nevada County Focus Group Participants indicated that Applied to Them (n=152)

Fields/Sectors Represented	Count	Percent*
Mental health consumer/client	48	32%
Family member of a mental health consumer/client	33	22%
Mental health service provider	48	32%
Substance use consumer/client	12	8%
Family member of a substance use consumer/client	16	11%
Substance use service provider	14	9%
Unhoused	18	2%
Family member of someone who is unhoused	9	6%
Service provider for the unhoused	12	8%
Community Member	66	43%
County Employee	31	20%
Law Enforcement	0	--
Educator/Teacher	11	7%
Advocate	18	12%
Member of a faith-based organization	20	13%
Member of a community-based organization	31	20%
Healthcare provider	7	5%
Other	21	14%
Other types of community health worker/case mgr.	10	7%
Peer support specialist	4	3%
Justice system partner (2)/Judge (2)	4	3%
Other (school board trustee, data analyst)	2	1%
Licensed marriage and family therapist	1	<1%

*Column Percent exceeds 100% as 96 survey respondents reported multiple roles.

Key Stakeholder Interviews

Eight Key Stakeholder Interviews were conducted between October and early November 2025. A brief description of the interviews conducted is provided in Table 4 below.

Table 4. Interviews Conducted

#	Group Description
1	Tribal and Indian Health Designees
2	Area Agencies on Aging
3	Independent Living Centers
4	Representatives from Youth from Historically Marginalized Communities
5	Representatives from LGBTQ+
6	Victims of Domestic Violence and Sexual Abuse
7	Representatives from Veteran Organizations
8	NCSOS

Stakeholder Survey

A stakeholder survey was conducted between mid-September and early October 2025. The stakeholder survey gathered further insight from key partners and stakeholders of Nevada County Behavioral Health. An overview of participants who completed the stakeholder survey is provided in the tables and figures below.

A total of 119 surveys were partially or fully completed. Of these, 94 were completed, and 25 were partially completed.

Upon further inspection, five of the partially completed surveys had data that could be included in the summary analysis, while 20 were excluded from the analysis due to a high rate of non-response.

STAKEHOLDER SURVEY

This section summarizes the demographic and service characteristics of stakeholders who participated in the 2025-2026 CPP Nevada County Stakeholder Survey. Below is a summary of findings organized by survey question.

Fields and Population Represented

Table 5 shows that Mental/Behavioral Health was by far the most represented sector, with nearly three-quarters (72%) of respondents working in this field. Social Services was the second most common sector at 17%, followed by Child Welfare at 8%. Substance Use Disorder Treatment (6%), Healthcare (5%), Education (4%), and Housing (4%) represented smaller but substantial portions of the workforce. No representation was reported from Faith-based Organizations, Labor Representative Organizations, Disability Insurers, Law Enforcement, or Public Guardian roles, suggesting potential gaps in these sectors or limited involvement in the survey.

Table 5. Fields/Sectors Nevada County Stakeholder Survey Respondents Reporting Working In (N=99)

Fields/Sectors Represented	Count	Percent*
Mental/Behavioral Health	71	72%
Social Services	17	17%
Child Welfare	8	8%
Other: Substance Use Disorder Treatment	6	6%
Healthcare	5	5%
Education	4	4%
Other: Housing	4	4%
Corrections/Probation	3	3%
Courts/Judicial	3	3%
Other: Public Health	3	3%
Other: Non-Profit/NGO (Youth Services, Homeless)	3	3%
Other: Veterans	2	2%
Other: Tribal(Health & Welfare/Social Services)	2	2%
Other: Family Resources	2	2%
Emergency Department	1	1%
Other: Fiscal	1	1%

*Column Percent exceeds 100% as 19 survey respondents reported working in multiple fields/sectors.

Figure 1 shows that early one-fifth (9%) of respondents worked across multiple fields/sectors, indicating cross-sector collaboration.

Figure 1. Nevada County Behavioral Health Stakeholder Survey Respondents Reported Number of Field(s)/Sector(s) They Work in (N=99)

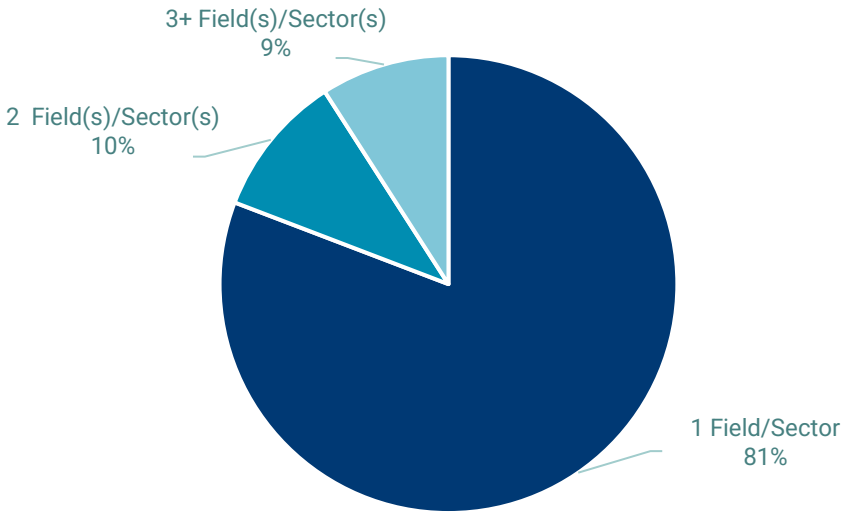


Figure 2 displays the participants' organizational affiliation with Nevada County Behavioral Health. The results show that 88% of respondents considered their organization part of Nevada County Behavioral Health (NCBH), while 12% did not. This distribution suggests NCBH utilizes county-affiliated and independent community providers.

Figure 2. Nevada County Stakeholder Survey Respondents Affiliation to NCBH (N=99)

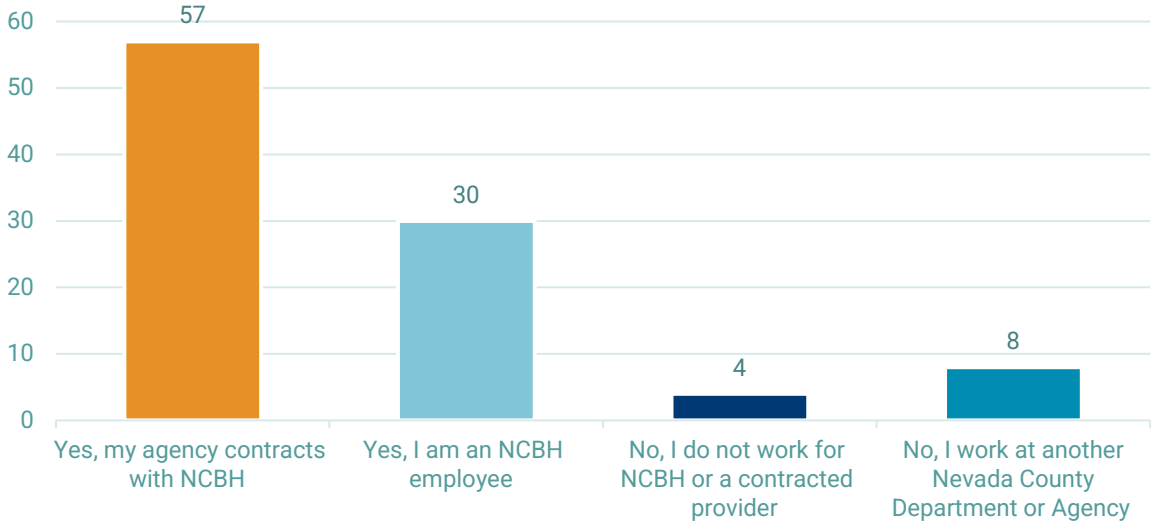


Figure 3 details the age groups served by Nevada County Behavioral Health. Adults (26-59 years) represented the largest primary service population at 64%.

One-fifth (20%) primarily served Youth and Young Adults (16-25 years), reflecting a focus on this critical transition period. Older Adults (60+ years) comprised 4% and Children (0-15 years) comprised 12% of the primary populations served.

Figure 3. Age Groups Nevada County Stakeholder Survey Respondents Work with the Most (N=99)

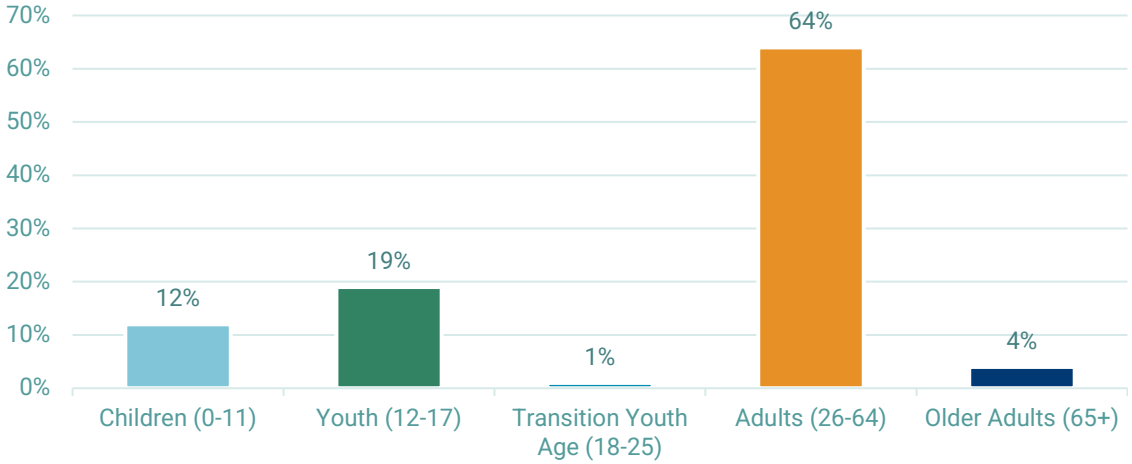
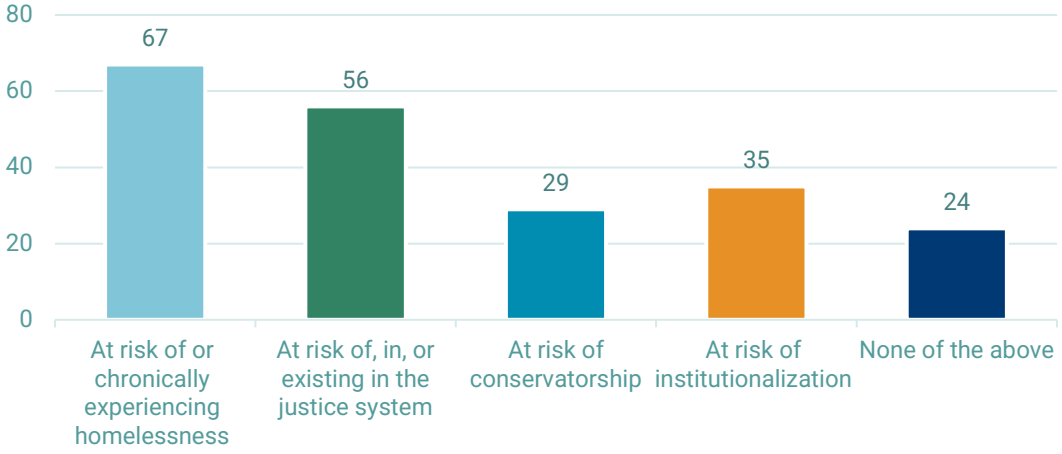


Figure 4 shows the priority populations served among the survey respondents. Individuals at risk of or chronically experiencing homelessness were the most commonly served priority population, with more than two-thirds (68%) of respondents providing services to this group. More than half (57%) served individuals at risk of, currently in, or recently exiting the justice system. More than one-third (35%) served those at risk of institutionalization. Less than one-quarter (24%) indicated they served none of these priority populations. The high overlap suggests many providers work with individuals experiencing multiple, intersecting risk factors, reflecting the complex challenges faced by Nevada County's residents.

Figure 4. Number of Nevada County Stakeholder Survey Respondents Who Reported Providing Services to Adult and Children Priority Populations (N=99)*



* Survey Respondents were instructed to select all priority populations that applied.

Table 6 displays the percentage of "targeted" and "culturally specific" services provided by the respondents. People with Disabilities were the most frequently served population receiving targeted services (39%), followed by LGBTQIA+ individuals (33%) and Latinx communities (28%). Nearly one-quarter (23%) of respondents provided services specifically targeting the Truckee geographic region. Veterans (16%) and Indigenous People (17%) also received culturally specific services from notable proportions of providers. Around one-quarter (24%) indicated they did not provide targeted services to any of the listed populations, possibly reflecting potential gaps in culturally specific programming. Additional populations identified included homeless individuals (5%), youth and families (5%), elderly/seniors (2%), and individuals with mental illness (2%).

Table 6. Populations Nevada County Stakeholder Survey Respondents Report Providing "Targeted" or "Culturally Specific" Services (N=99)

Population Descriptions	Count	Percent*
Veterans	16	16%
People with Disabilities	39	39%
LGBTQIA+	33	33%
Latinx	28	28%
Indigenous People	17	17%
Truckee (geographic region)	23	23%
Other, specified:		
▪ Individuals with Mental Illness	2	2%
▪ Elderly/Seniors	2	2%
▪ Homeless	5	5%
▪ Youth and Families	5	5%
▪ Substance Use Population	1	1%
None of the Above	24	24%

*Column Percent exceeds 100% as survey respondents were instructed to check all populations that applied.

Behavioral Health Services Act-Related Services

Table 7 shows that Mental Health Services were provided by the vast majority (71%) of respondents, closely aligning with sectoral representation. More than one-quarter (27%) provided Substance Use Disorder Services. Youth-Specific Services (25%) and Housing (23%) were also commonly provided services. Very few respondents (6%) indicated they provided none of these BHSA-related services. The overlap in services suggests many providers offer integrated support to clients.

Table 7. Behavioral Health Services Act-related Services Primarily Provided by Nevada County Stakeholder Survey Respondents (N=99)

Behavioral Health Services Act-related Services	Count	Percent*
Mental Health Services	70	71%
Substance Use Disorder Services	27	27%
Housing	23	23%
Youth-Specific Services	25	25%
None of these	6	6%

*Column Percent exceeds 100% as survey respondents were instructed to check all BHSA-related services that applied.

Table 8 shows the Components of Care. Outpatient or Intensive Community-Based Services represented nearly two-fifths (39%) of primary service provision, indicating a strong commitment to community-based care. One-fifth (20%) of respondents primarily provided Prevention or Early Intervention Services, reflecting investment in upstream interventions. Field-Based Services (10%), Residential

Treatment Services (9%), Housing Intervention Services (7%), and Crisis Services (5%) comprised smaller portions of the care continuum. Other services included fiscal management, advocacy, peer support, tribal support, and navigation services.

Table 8. Components of Care Services Nevada County Stakeholder Survey Respondents Reporting Primarily Providing (N=98)

Components of Care Services Provided	Count	Percent
Prevention or Early Intervention Services, Including Education	20	20%
Outpatient or Intensive Community-Based Services	38	39%
Field-Based Services	10	10%
Housing Intervention Services	7	7%
Residential Treatment Services	9	9%
Crisis Services	5	5%
Inpatient/Hospital Services	0	--
Other, specified:		
▪ Fiscal	1	1%
▪ Advocacy	1	1%
▪ Peer support	1	1%
▪ Tribal support	2	2%
▪ Not a provider	2	2%
▪ Navigation/independent living skills	1	1%
▪ Multiple services listed	1	1%

Behavioral Health Service Effectiveness

Table 9 details the top housing needs among Nevada County Medi-Cal Recipients. Community-Based Supportive Housing was identified as the top housing need, with nearly half (47%) of respondents selecting this option. Transitional housing programs were the second most identified need at 23%. Housing Coordination/Navigating Services represented 17% of responses. Emergency Shelter (5%) and Transitional Housing Programs (5%) were less frequently identified as top priorities. Low-income Permanent Housing represented 4% of responses. Youth residential and Residential SUD/Recovery Housing each represented only 1% of responses.

The strong emphasis on community-based supportive housing aligns with the high need for housing services identified in the mental health and substance use service questions, reflecting a preference for housing models that integrate wraparound support services.

Table 9. Top Housing Needs Among Nevada County Medi-Cal recipients a Identified by Nevada County Stakeholder Survey Respondents (N=94)

Population Descriptions	Count	Percent
Emergency Shelter	5	5%
Transitional Housing Programs	22	23%
Community-Based Supportive Housing	44	47%
Housing Coordination/Navigating Services	16	17%
All of the Above	1	1%
Other, specified:		
▪ Low Income Permanent Housing	4	4%
▪ Youth residential	1	1%
▪ Residential SUD/Recovery Housing	1	1%

Figure 5 shows the rate of need for mental health services among Medi-Cal Recipients. Housing services showed the highest rate of need, with an overwhelming majority (92%) of respondents rating the need as high and no respondents rating it as low. Early intervention services demonstrated a strong need, with nearly three-quarters (71%) rating the need as high and only 2% rating it as low. Crisis intervention/stabilization services also showed substantial need, with more than two-thirds (69%) rating the need as high and 4% as low. Outpatient/community-based services showed that more than half (59%) rated the need as high, and 2% rated the need as low. Peer support services and intensive community-based services showed moderate-to-high need patterns, with 43% and 53%, respectively, rated the need as high. The lowest perceived need was for inpatient hospital services.

Figure 5. Rate of Need for Mental Health Services Among Nevada County Medi-Cal Recipients

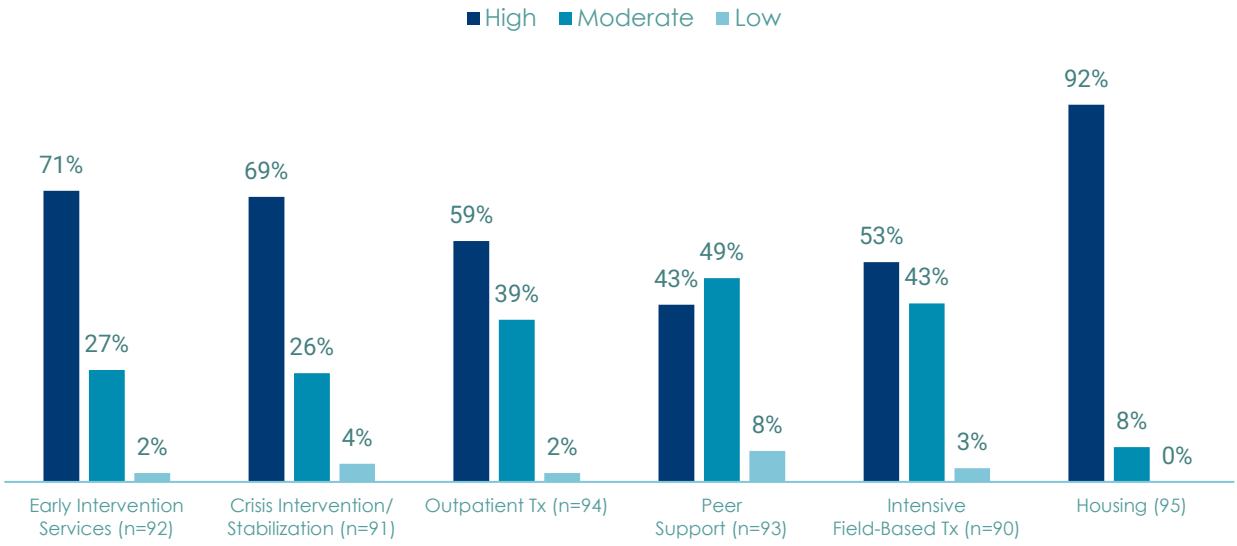
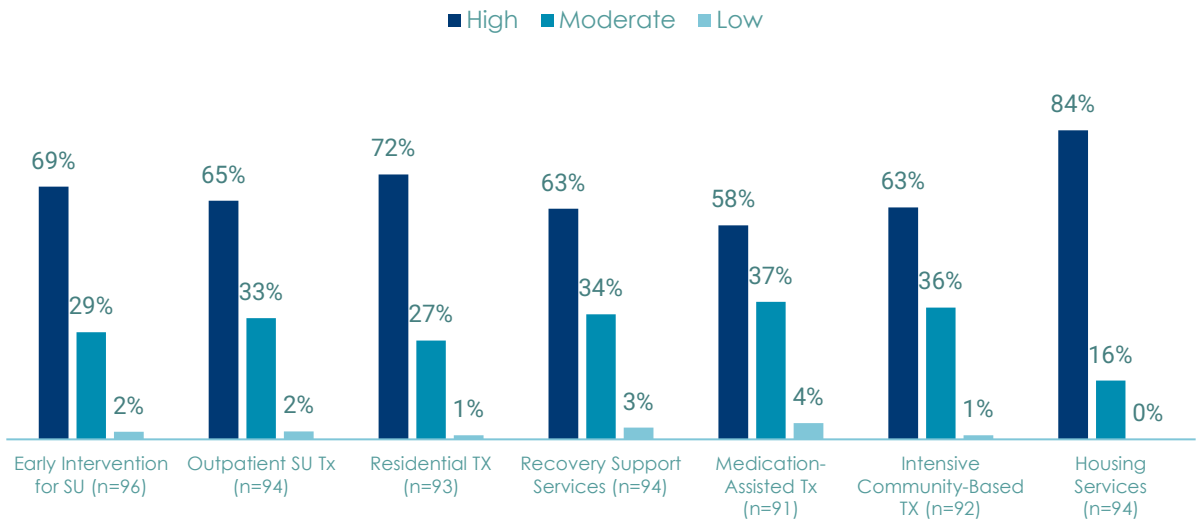


Figure 6 details the rate of need for substance use services among Medi-Cal Recipients. Housing services again emerged as the highest-priority need, with 84% of respondents rating the need as high and only 1% rating it as low. Residential treatment services showed nearly three-quarters (72%) rated the need as high, and 1% rated the need as low. Early intervention services and outpatient/SUD treatment both demonstrated a strong need, with 69% and 65%, respectively, rating the need as high. Recovery support services showed 63% rating the need as high and 3% as low. Medication-assisted treatment and intensive community-based services both showed more than half (58% and 63% respectively) rated the need as high. Across all substance use service categories, very few respondents rated the need as low (ranging from 1% to 4%), indicating overall substantial service gaps for substance use.

Figure 6. Rate of Need for Substance Use Services Among Nevada County Medi-Cal Recipients



Barriers

Table 10 presents the barriers that respondents have observed their clients and the community face. Perceived lack of transportation emerged as the most critical barrier to accessing behavioral health care, with 83% rating it as "somewhat" or "a lot" of a barrier. Local services not available were the second-highest concern at 69%, followed by excessive delay in getting an appointment at 58% and the cost of care at 57%. Moderate barriers included the inability to take time off work (54%) and the lack of educational outreach (49%). In contrast, discrimination/unfriendliness of providers (12%), language barriers (33%), and concerns about quality of care (28%) received relatively lower ratings. The data indicate that access challenges are more structural and systemic rather than interpersonal or quality-related issues.

Table 10. Barriers for People Accessing Behavioral Health Care in Nevada County

Statements	N	None	A Little Bit	Somewhat	A Lot
Cost of care	90	23%	20%	29%	28%
Lack of transportation	92	4%	13%	38%	45%
Inability to take time off work for an appointment	90	16%	31%	37%	17%
Lack of educational outreach and awareness	91	19%	32%	36%	13%
Language barrier/communication difficulties with providers	90	31%	36%	21%	12%
Discrimination/unfriendliness of providers	90	49%	39%	10%	2%
Concerns about the quality of care or diagnosis	90	33%	38%	24%	4%
Excessive delay in getting an appointment	90	16%	27%	29%	29%
Local services not available	86	14%	17%	29%	40%

Agreement on System Capacity Statements

Displayed in Table 11 (Appendix 3), Nevada County stakeholders were surveyed regarding various aspects of behavioral health system capacity, revealing a gap between provider knowledge and system performance. Respondents strongly agree and agree ratings in knowing where to refer clients for mental health services (82%), substance use disorder treatment (76%), and housing support (75%). However, confidence that these referrals would result in successful service delivery decreased. Only 45% believed clients would receive needed mental health services, 47% for substance use disorder services, and just 42% for housing services.

Providers understand the referral landscape but have learned through experience that knowing where to refer does not guarantee access to services for their clients. The housing system emerged as the area of greatest concern, with the lowest confidence rating across all survey statements. Additionally, only

53% of respondents reported having effective follow-up processes for referrals to Nevada County Behavioral Health, with 12% expressing no opinion, the highest uncertainty rate for any question, suggesting inadequate closed-loop referral systems.

Respondents expressed confidence in their organizations' inclusive service capacity (88%) and telehealth adoption (77%), indicating progress in modernizing individual service delivery. However, 77% agreed that behavioral health education gaps exist in the community, citing insufficient prevention and early intervention programs. The data reveal a system where individual providers are knowledgeable and equipped, but system-level coordination, capacity, and follow-through remain notable challenges.

Qualitative Analysis of Priority Improvement Areas

Finally, an open-ended question asked respondents to identify the most important actions to improve behavioral health care quality and availability. Sixty-six stakeholder responses revealed four priorities. Care coordination emerged as the dominant concern (35% of responses), with stakeholders calling for better collaboration across agencies, simplified system navigation, closed-loop referrals, and improved outreach. Respondents emphasized that the current system is too complex for both clients and providers to navigate effectively, despite the existence of many individual services.

Staffing challenges were reported in 23% of responses, with stakeholders emphasizing not only hiring more providers but also improving retention through competitive pay, manageable caseloads, and opportunities for advancement. Bilingual and culturally competent staff were specifically identified as a need, particularly Spanish-speaking providers. Housing concerns were reported in 20% of responses, with an overwhelming emphasis on supportive housing models that include wraparound services rather than shelter alone. Multiple respondents noted that housing instability undermines all other behavioral health interventions, with long wait times (2-3 years for some programs) creating critical gaps. Transportation barriers appeared in 9% of responses, consistently described as a notable obstacle in Nevada County's rural geography.

BHSA GOALS

Introduction

The Behavioral Health Services Act requires counties to meet six priority goals: 1) Access to Care, 2) Homelessness, 3) Institutionalization, 4) Justice Involvement, 5) Removal of Children from Homes, and 6) Untreated Behavioral Health Conditions. For each goal, there are primary indicators that counties can use to compare their performance to state-level performance.

Furthermore, the Behavioral Health Act outlines additional goals that counties can choose to meet. The additional goals of interest to Nevada County Behavioral Health are 1) Overdoses and 2) Care Experience. As with the priority goals, county performance is compared to **state-level** performance.

This section will provide qualitative insight into the priority goals and additional goals on which Nevada County Behavioral Health is underperforming. The analysis will begin with qualitative findings relevant to underperforming primary measures of priority goals and conclude with qualitative findings relevant to selected underperforming primary measures of selected additional goals.

Primary Goals

Of the six priority goals, there were only qualitative insights into one indicator on which Nevada County was underperforming. This indicator, "People Experiencing Homelessness," was for the priority goal of Homelessness. The data show that Nevada County had a higher rate of people experiencing homelessness than the state.

Homelessness: High Rate of Homelessness

Across a wide range of focus groups and key stakeholder interviews, participants discussed what they perceived to be the ***high rate of homelessness*** that Nevada County is experiencing. For example, in the Youth Consumer Caregiver focus group, not enough housing for those with a serious mental illness was described as "a constant challenge," with a participant explaining that "the housing situation is dire." More broadly, in the Healthcare Provider focus group, when discussing the unhoused, participants described how "there are no places for them to go." Furthermore, a breakout session of the Nevada County Behavioral Health Staff focus group, a participant described how a "persistent lack of housing remains a major issue." Finally, an interviewee described how for the LGBTQ+ community, "homelessness is a huge risk…because of family rejection."

The issue was also present in Truckee, as the Truckee Adult Mental Health Consumer focus group described how "finding housing is a joke" and that there were no "temporary place[s] to sleep at night in Truckee." A participant from the

same focus group described how they perceived a lack of "places for animals and people," noting that individuals with pets were often denied access to shelters.

These findings highlight what participants saw as a need for housing in Nevada County. Participants from both the Western and Eastern parts of the county described homelessness as a notable issue. These findings reinforce the quantitative findings on the high levels of homelessness in Nevada County.

Additional Goals

The additional goals of interest to Nevada County Behavioral Health are 1) Overdoses and 2) Care Experience. For the additional goal of Overdoses, the qualitative data provided insight into the indicator of "The Rate of All Drug-Related Overdose Deaths." For this indicator, Nevada County had a higher rate than the state. For the Care Experience goal, the qualitative data provided insight into the indicator of "Adult Perception of Cultural Appropriateness," on which Nevada County scored lower than the state.

Overdoses: Drug-Related Overdose Deaths

The qualitative data provide insight into the issue of ***drug-related overdose deaths***. The theme of overdoses was discussed three times in the data. One participant discussed steps that can be taken to prepare those in the support systems of individuals who have a substance use disorder, while two other participants discussed steps that can be taken to enhance the continuum of care for those who overdose.

First, feedback was shared regarding steps that can be taken to prepare those in support systems of individuals with a substance use disorder. In the Western County Educators focus group, when asked about feedback regarding services for individuals with a substance use disorder, one participant shared that they wanted to see "families and teachers being prepared to administer [Narcan] when [an] overdose occurs."

Second, participants discussed steps that can be taken to enhance the continuum of care for those who overdose. A participant in the Truckee English-speaking providers focus group shared that they wished to see "services to support individuals" who overdosed. Furthermore, in the Overdose Prevention Coalition focus group, a participant shared that in their experience, there was "no comfortable place for unhoused people to stay after an overdose."

Taken together, this feedback recommends that NCBH combat overdose deaths through a multi-pronged approach. On the one hand, NCBH can train those in the support system of individuals with a substance use disorder on how to use Narcan. On the other hand, the continuum of care could be enhanced with

further services and resources to support those who overdose, including housing for unhoused individuals recovering from an overdose.

Care Experience: Perception of Cultural Appropriateness

Across a wide array of focus groups, as well as a key stakeholder interview, participants provided insight into their perception of Nevada County Behavioral Health as delivering care that could be ***more culturally appropriate***. For example, one NCBH staff member described this as "a gap in support for Spanish-speaking adults." Another NCBH staff member described "services for immigrants, refugees, [and] Native Americans" as a gap in NCBH services. In more direct terms, an NCBH contractor said the "cultural competency" is a gap in services for those with a Serious Mental Illness.

Most of the feedback on this issue came from Truckee focus groups. One Spanish-speaking provider explained that from their perspective, there were "no services in Spanish." At a different point in the focus group, a participant described how there were "only two Spanish-speaking providers for the entire county." Furthermore, a Spanish-speaking provider explained that in Truckee, there is only one Spanish-speaking provider for Substance Use Disorder. Finally, a Spanish-speaking provider encouraged "bilingual service expansion."

These findings underscore the need, from both the perspective of providers and NCBH staff, for increased Spanish-language services and a greater number of bilingual providers. Insight was also provided on the perceived need to expand services to more vulnerable populations, such as refugees and Native Americans.

Conclusion

Qualitative findings provide key notable insights into Nevada County's underperformance on one priority goal and two additional goals. For the priority goal, the findings indicate the extent to which homelessness is a notable issue in the county, which could therefore become a funding priority. The findings on the additional goals highlight what participants saw as the importance of providing support for those who overdose, as well as culturally competent care.

CRISIS SERVICES

This section focuses on qualitative feedback regarding Crisis Services, a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Crisis Services. Next, it will discuss participants' feedback on the limits of Crisis Services. Finally, this section will conclude with recommendations that participants offered to improve Crisis Services.

Strengths

The biggest strength of crisis services, as emphasized by participants, is the ***existence and performance of the different crisis services and their staff***. From the Mobile Crisis Team, to the CSU, and the CIT, this theme was the most common among all themes across the focus groups and key stakeholder interviews. For example, NCBH staff said that "the mobile crisis team is working well and maintains good communication with staff when their clients engage with crisis services." Similarly, Western County Educators explained that "Mobile crisis unit is going well with response and having a mental health provider come and follow up with the parent on resources."

The Mental Health Advisory Board echoed these sentiments, explaining that the "Mobile Crisis Team is an asset" and that "CSU is a strength." Furthermore, a participant from the Truckee English-speaking providers explained that "having a mobile crisis team [Sierra Mental Wellness Group] at the hospital is working really well…[they have the] direct ability to respond." Finally, an interviewee explained that "The Mobile Crisis team is incredibly beneficial and needed." These findings indicate that across a wide range of community members and stakeholders, there is a perception that crisis services are highly effective and that the staff is doing an excellent job.

Limits of Services

Although crisis services were emphasized as a notable strength of the continuum of care, participants also discussed service issues, such as response times, as well as concerns with crisis lines.

First, participants discussed service issues such as "***response time***" and "follow-through" for crisis services, as some participants felt that services could be improved by being delivered in a more timely manner and with follow-up after care is delivered. For example, regarding response time, a participant in the Western County Educators focus group explained, "Response time isn't as quick, but I haven't had to call them in a while." Participants also described issues such as follow-through. For example, a participant in the Truckee Spanish-Speaking Provider focus group explained that, in their view, a limitation of crisis services was

the lack of "no follow-up or sustained support after crisis." This was echoed by an NCBH staff member, who described how "when someone receives mobile crisis services, follow-up could be more seamless; as it's difficult, especially during late-night hours like 2am, clients may receive resources but not follow through."

Participants also described ***service issues they saw with crisis lines***, including issues with customer service and staffing issues. For example, a participant from the Mental Health Advisory Board explained that they believed people who answer crisis line hotlines "don't have much experience or wisdom," while another participant shared that "one time no one answered the phone" at a crisis line when they called. An Adult Mental Health Consumer focus group participant offered a similar assessment, explaining that there was "not enough time to talk" on the crisis line due to staffing issues. Later in this same focus group, a participant explained that the "crisis line seems overburdened."

Taken together, these findings indicate that while widely regarded as a valuable resource, crisis services have room for improvement. Such improvement, from the participants' perspective, would entail decreased response times, increased follow-through after crisis services, increased staffing at crisis lines, and improved crisis line customer service.

Recommendations

Participants offered two main suggestions to enhance crisis services. First, participants encouraged the county to increase outreach and education efforts around crisis services. Second, participants described how they would like to see crisis services expanded.

First, participants requested that the county ***increase outreach and engagement for crisis services***. This entails intensified efforts to raise public awareness of crisis services, as well as enhanced education about these services. For example, in the Criminal Justice focus group, one participant explained that "With mobile crisis, lots of people who don't know what it does, how to do it, and utilize it." Similarly, an interviewee described how there was a "bit of confusion on the types of crises."

To combat this type of confusion, a participant in the Truckee English-Speaking Provider focus group recommended a "Centralized resource directory for all behavioral health programs and providers" as a way to address any perceived public confusion around crisis services. In addition to public outreach, focus group participants also encouraged outreach and education of law enforcement. For example, a participant in the Unhoused focus group explained that they would like to see "training for law enforcement on mental health crises, suicide prevention, and appropriate response."

Second, participants described their ***desire to see crisis services expand***. An NCBH staff member explained that "a more robust Crisis Stabilization Unit (CSU) is

needed for overnight stays; currently there are about four beds, and not everyone meets the criteria to stay, making it difficult for some to find a place to go." Similarly, a participant in the Western County Educators focus group explained that they "would like a local 988 call center – understanding is that 988 calls go to Sacramento right now so people who use it aren't receiving services about the local crisis unit in the county." Finally, a participant in the Unhoused focus group expressed a desire for "properly staffed mobile crisis team that responds immediately without wait times."

Taken together, these recommendations encourage the county to increase outreach and training efforts regarding crisis services, as well as expand these services. Suggestions for outreach ranged from a unified directory of all behavioral health services to increased training for law enforcement about mental health crises. Furthermore, recommendations for expanding crisis services discussed the need for additional staff, a local 988 call center, and increased capacity.

HOUSING

This section focuses on qualitative feedback on Housing Services, a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Housing Services. Next, it will discuss participants' feedback on the limits of Housing Services. Finally, this section will conclude with recommendations that participants offered to improve Housing Services.

Strengths

For the strengths of housing services, participants discussed ***specific housing programs***. For example, HOME Team was mentioned by various participants as a strength. An NCBH staff member explained how "HOME team's outreach and engagement efforts have increased client involvement when they do connect with services." Other programs that were mentioned as strengths include Sierra Outreach Services, Hospitality House, Spirit Center, Sierra Community House, The Stagecoach Project, and FREED.

Limits of Services

Participants emphasized two main limits of housing programs. First, they discussed negative service experiences. Second, they discussed the limits of the transitional process.

Participants discussed their ***negative service experiences with housing services***. These negative experiences ranged from facing organizational barriers to navigating services, accessing services, and experiencing staffing issues, as well as delays in service delivery. For example, a participant in the Unhoused focus group explained how they have "been on the waiting list for apartments for less than a year - doesn't matter if you have a full-time job within two weeks of getting out of jail, still homeless." Later in the focus group, a participant described how they wished there was "better coordination between all organizations - have them meet with people with lived experience." These issues were also salient for NCBH staff and service providers. For example, an NCBH staff member explained how "it would be ideal to provide housing support while paperwork is collected, rather than requiring all documentation to be completed before housing can begin."

Next, a limit of service that participants described was the ***transitional process***. This means that participants discussed the issues that people faced in transitioning from being unhoused to having permanent housing. This includes issues with transitional housing, care, coordination, and services. For example, a participant in the Mental Health Advisory Board focus group stated that we "need more transitional housing in our community." Similarly, an NCBH staff member

described the need for "transitional housing, more places with longer stays, [and] better collaboration with Permanent Supportive Housing contractors to adjust to take people with increased need." Participants with lived experience echoed this theme. A participant in the Adult Mental Health Consumers focus group described a need for "more transitional and permanent affordable housing," as well as for "youth transitional housing." The participant described how homeless youth were "sleeping in the woods [and] couch surfing."

Taken together, these findings highlight the limitations of housing services in terms of service experience and services related to transitional housing. As NCBH transitions to the Behavioral Health Services Act, these are areas that it could prioritize.

Recommendations

Participants across focus groups emphasized two major themes for recommendations for housing services. First, they discussed the need for financial aid and housing for the unhoused. Second, they recommended more housing and integrated services for those with a serious mental illness, a substance use disorder, or a co-occurring substance use disorder and mental illness.

First, participants recommended an array of ***financial and housing support for the unhoused***. For example, one NCBH staff member recommended "longer-term funding for transitional housing." Similarly, a participant in the Contractor focus group discussed how "finding permanent housing" for the unhoused should be a priority of the county. Those with lived experience voiced similar desires. One participant explained, "Financial aid or direct financial assistance to those who are incapable of starting somewhere doesn't exist and is needed." Finally, an interviewee recommended that NCBH "[build] more accessible housing."

Second, the qualitative data focused on ***providing housing for individuals with SUD, SMI, and co-occurring conditions***. In the Youth Consumer Caregiver focus group, participants reported a lack of housing options for individuals with SMI. The participant said that providing this housing is "a constant challenge…if they're not stable in housing, then there are a lot of other issues." The participant concluded by explaining how "the housing situation is dire" for those with SMI and SUD. Finally, a participant in the Adult Mental Health Consumer focus group explained how they wanted to see "more housing…[for] those with MH services. More than just a handful of apartment complexes, so much room for tiny homes."

Taken together, these findings emphasize what participants saw as the need for housing for the unhoused, those with an SUD, those with SMI, and those with a co-occurring SUD and SMI. These priorities align with BHSA priorities. The findings then reaffirm that priorities outlined by BHSA and suggest that NCBH could prioritize providing housing for these groups.

SEVERE MENTAL ILLNESS (SMI)

This section focuses on qualitative feedback on Serious Mental Illness Services (SMI), which are a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Serious Mental Illness Services. Next, it will discuss participants' feedback on the limits of Serious Mental Illness Services. Finally, this section will conclude with recommendations that participants offered to improve services for individuals with Serious Mental Illness.

Strengths

Participants highlighted two main strengths of services for those with serious mental illness. First, they emphasized the quality of services. Second, they discussed specific programs that they considered strengths.

First, participants described the ***experience and quality of services for those with a serious mental illness*** as a strength. For example, a participant from the Youth Early Intervention Providers focus group shared that the "county is doing a good job for SMI." Additionally, a participant in the Adult Mental Health Consumers focus group stated, "Case managers are doing a fabulous job." Finally, an interviewee explained that for staff treating SMI, "They are very busy and often overwhelmed, but they really do work well together."

Second, participants describe ***specific SMI programs that they believed were working very well***. Programs such as TTUSD Wellness Centers were highlighted by participants. One participant in the Overdose Prevention Coalition focus group explained that "TTUSD Wellness Centers and staff that are trained are doing a fantastic job. TTUSD is a leader in mental health services, staff, and specialists, and has grown incredibly. Having wellness centers in all our schools is not common." Tahoe Forest Hospital System and Odessey House were mentioned as strengths of SMI services.

Taken together, these findings show that the strengths of the Nevada County continuum of care for SMI include service experience and specific programs. This means that NCBH staff and providers, as well as programs such as TTUSD Wellness Centers and the Odyssey House, were highlighted by participants.

Limits of Services

While participants highlighted the strengths of the services, they also discussed the limitations of these services. The major themes that emerged among participants as limitations of services included issues with coverage for SMI services, as well as concerns about outreach and education.

Participants described what they perceived as a ***lack of coverage*** as a major theme. This was one of the most commonly observed themes throughout the qualitative data. "Lack of coverage" refers to participants' feelings that SMI services did not cover them or their loved ones. This often included a perceived lack of emphasis on prevention, as well as issues that participants had with NCBH's definition of "severe" when defining what a severe mental illness was. For example, one participant in the NAMI focus group explained that they tried to get help for someone who was starting to spiral and was showing signs of an episode. The participant wanted NCBH to intervene, but was told that the situation was not severe enough to warrant treatment. The participants described how they were "knocking at the door" for help before things got worse, but "the gate still is closed rather than open." These findings show the potential for clearer eligibility criteria for county behavioral health services.

This was echoed in the Youth Consumer Caregiver focus group, as one participant said, "The word is severe. What defines severe?" The participant went on to explain that the problem is that NCBH only offers help for those with severe mental illness. Later, the participant explained that "This word 'severe' seems to rule the world. What seems severe to you might be different from what I look at." The participant concluded by explaining, "I have to prove how severe it is…I know what's going on, I know the signs, why won't you help me?"

Another prominent theme that was voiced often throughout the data was the ***need for outreach and education***. For example, one NCBH staff member explained, "Some of the challenges may be educational, supporting family members to make a phone call, helping case managers take notes, and managing conflicts that may arise." Furthermore, a participant in the Adult Mental Health Consumer focus group explained that they wanted to see "more focus on education on diagnosis, understanding your own diagnosis and how to live with it." Finally, a participant in the Truckee Adult Mental Health Consumer focus group said that a limit was that there was "not enough promotion of services and knowledge shared, worried that making more money might lead to loss of services such as medical."

Recommendations

Finally, a major theme for recommendations for SMI services emerged from the data. Participants recommended increasing programs that aimed at stigma reduction.

Stigma reduction was the main recommendation that emerged from the data. Stigma reduction was deemed necessary by participants for the public, as well as for staff and law enforcement. In the Healthcare Providers focus group, one participant explained that they would like to see a partnership with NCBH "so hospital staff are not afraid of mentally ill patients." Similarly, participants discussed what they perceived as a need to reduce the stigma of parents of children with

SMI. For example, a participant in the Mental Health Advisory Board focus group described how "Parents can be blamed for their child's mental illness."

This was echoed in the NAMI focus group, as one participant shared that "too often [the family] is blamed" for their child having an SMI. Later in the focus group, a participant described how "providers make parents feel like they are crazy. [They] lecture parents for being late when they are overwhelmed with taking care of SMI children. [There is a] lack of empathy among providers." A solution for reducing stigma, as identified by a NAMI focus group participant, was to involve parents: "Parents could be a huge part of the solution if they were educated and approached properly."

SUBSTANCE USE DISORDER (SUD)

This section focuses on qualitative feedback on Substance Use Disorder Services (SUD), which are a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Substance Use Disorder Services. Next, it will discuss participants' feedback on the limits of Substance Use Disorder Services. Finally, this section will conclude with recommendations that participants offered to improve Substance Use Disorder Services.

Strengths

Participants highlighted ***specific SUD programs*** as strengths. In particular, participants discussed substance use navigators, community health workers, "telehealth options," "County SUD screening clinics," and County-contracted vendors as strengths of SUD services.

Limits of Services

Participants discussed the limits of SUD services. In particular, the two major themes that emerged were a perceived lack of services for minors and a perceived lack of services in Truckee.

Participants described how they perceived there to be a ***lack of SUD services for minors***. For example, one NCBH staff member stated that "low-barrier SUD treatment for youth is needed." Moreover, a participant in the Mental Health Advisory Board focus group explained that there was a "gap in services for youth and youth with SUD…[youth have] two options and if neither of those options work out," they have no more options. They went on to explain that "With adults you can do SUD screening but not with youth…at the end of the day, there were no options presented because [the consumer was] underage." Finally, a participant in the Overdose Prevention Coalition focus group described how there was a gap in "youth treatment in general – what is available? How do referrals happen?" This feedback shows what participants perceived as the need for enhanced youth SUD services for minors that can serve an increased number of individuals.

Furthermore, participants described what they perceived to be a ***lack of services in Truckee***. A participant in the Criminal Justice focus group said that "Truckee [is] very underserved" in the areas of SUD services. This was echoed by Truckee Spanish-Speaking Providers. They described how, for SUD services, they faced "geographic limitations." In particular, they described how "previous services in Kings Beach absorbed and withdrawn…[we] used to have an office with three people, one Spanish-speaking. Now nothing is available in the area."

Recommendations

Two major themes emerged from the data for recommendations for SUD services. Participants emphasized the importance of education and stigma reduction around SUD, as well as the need for a Detox Center and Residential Care.

One of the most prominent themes across all of the focus groups and interviews was the recommendation by participants for ***more education and stigma reduction around SUD***. In the Healthcare Provider focus group, one participant described how there was substantial "stigma for someone [in the] mental health system or [with a] substance use disorder." They recommended "[addressing] both training and stigma through one training." The need for education was then emphasized by a participant in the Youth Early Intervention Provider focus group, who explained that they would like NCBH to find "a way to make it common knowledge for youth to easily access substance abuse services." In terms of educating consumers, an NCBH staff member suggested "teach[ing] clients how to manage their triggers from the very beginning." Finally, from the side of those with lived experience, a participant in the Adult Mental Health Consumer focus group expressed the desire to see "[a]dditional training and education with mental health."

Finally, participants stressed the ***need for a Detox Center, as well as for expanded Residential Care***. Regarding a Detox Center, one participant in the Truckee English-Speaking Provider focus group explained that they perceived there to be a "lack in detox centers, and it is difficult to get into the beds." Similarly, an interviewee explained that "[t]here just are not enough treatment or detox facilities." A solution was suggested by the Criminal Justice focus group, where a participant said NCBH should "[a]dd a detox or sobering center."

Regarding expanding Residential Care, a participant from the Overdose Prevention Coalition focus group described how this perceived need extended to "SUD residential treatment for patients – [there] just doesn't seem to be enough." Similarly, a participant in the Healthcare Provider focus group suggested a solution: that there was a "[n]eed for sobering centers and residential treatment beds for the medical population/uninsured."

WORKFORCE

This section focuses on qualitative feedback regarding aspects of the Workforce, a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about the Workforce. Next, it will discuss participants' feedback on the limits of the Workforce.

Strengths

Focus group participants described two major strengths of the NCBH workforce. First, they described NCBH employees and collaborators as a strength. Second, they described the strong workplace culture of NCBH as an additional strength.

The second most common theme across all of the interviews and focus groups was that the ***NCBH workforce was a major strength***. Participants described NCBH staff, employees, case managers, management, volunteers, and board members as a major strength of the NCBH continuum of care. An internal perspective was voiced by an NCBH staff member, who said that NCBH is "a great team" and that their coworkers are "fantastic." Similarly, the Mental Health Advisory Board praised the "compassion" of the NCBH workforce and the "staff's ability to cooperate with consumers and other organizations." A participant added, "We think Phoebe is great! We have a great director." The participant went on to describe how the "state board has said that Nevada County is one of the most collaborative in the state." This sentiment was echoed by consumers as well. A participant in the Adult Mental Health Consumer focus group added that NCBH "offers more than most counties. [They] are already doing a fantastic job already between psychiatrists, peer support people, therapists doing a fantastic job with what they have."

The second major theme that emerged was ***praise for NCBH's workplace culture***. For this theme, participants described the strength of the NCBH workforce as characterized by a strong workplace culture that demonstrates coordination, innovation, and effective management approaches. For example, an NCBH staff member explained that NCBH's "safe, healthy work culture equips staff to serve the community better." Similar sentiments were echoed widely among the different NCBH staff focus groups. From an external perspective, an interviewee explained that they "feel good to partner with NCBH."

Limits of Services

Finally, the central theme that emerged across the interviews and focus groups regarding the limits of the NCBH workforce was the ***issue of staffing***. Participants discussed the perceived lack of staff, noted what they believed was high turnover, and expressed their concerns about the need for enhanced timeliness of services. In the Criminal Justice focus group, for example, a participant discussed how there were, in their opinion, "not enough behavioral health

workers…NCBH should double the number of people helping out their clients." From the consumer perspective, the issue of turnover was noticeable. For example, a participant in the Youth Consumer Caregiver focus group explained that "[t]here's just so much turnover it's become quite the barrier to families receiving services."

CONCLUSION

The 2025-2026 Community Program Planning Process for Nevada County's Behavioral Health Services Act (BHSA) Integrated Plan engaged both system stakeholders and community participants between August and October 2025. Data collection included 16 focus groups with community members and individuals with lived experience, eight key stakeholder interviews with system partners representing the required stakeholder categories, one survey, and one demographic form. System stakeholders included representatives from mental and behavioral health agencies, social services, child welfare, substance use disorder treatment programs, healthcare providers, education, tribal organizations, veterans' services, LGBTQ+ advocacy groups, domestic violence services, independent living centers, and aging services. Community participants included mental health consumers, family members and caregivers, youth, unhoused individuals, Spanish-speaking community members, and various provider groups who shared their experiences and perspectives on behavioral health services in Nevada County.

Summary of Key Findings

CRISIS SERVICES

Crisis services, particularly the Mobile Crisis Team and Crisis Stabilization Unit (CSU), were identified as major strengths across stakeholder groups. Staff performance and coordination received consistent praise from educators, providers, and community members. However, participants noted what they saw as areas for improvement, including follow-through after crisis intervention, crisis line staffing, and an enhancement of the timeliness of services. Some callers reported difficulty reaching crisis lines or feeling rushed during calls. Stakeholders recommend expanding crisis service capacity, establishing a local 988 call center (calls currently route to Sacramento), increasing CSU bed capacity beyond the current four beds, and improving outreach to both the public and law enforcement. A centralized resource directory was also suggested to reduce confusion about available crisis services and how to access them.

HOUSING

Specific housing programs, including HOME Team, Sierra Outreach Services, Hospitality House, and Spirit Center, were recognized as strengths. However, housing emerged as the most critical need across all service areas, with 92% of survey respondents rating it as a high priority. Participants described a perceived

need to enhance the timeliness of services, issues with documentation requirements prior to housing placement, and challenges with coordination between organizations. The transitional housing process was identified as an area in which participants perceived an opportunity for growth, with a perceived need for more options for youth and enhanced support during the transition to permanent housing. Stakeholders strongly recommend expanding community-based supportive housing with wraparound services, increasing transitional housing capacity, providing longer-term funding, and streamlining the application process. Housing for individuals with serious mental illness, substance use disorders, and co-occurring conditions was emphasized as a priority aligned with BHSA requirements.

SEVERE MENTAL ILLNESS (SMI)

Service quality and case management for SMI were praised, with TTUSD Wellness Centers, Tahoe Forest Hospital System, and Odyssey House highlighted as exemplary programs. However, participants highlighted what they perceived to be some issues with service eligibility criteria. Parents and caregivers expressed frustration that the definition of "severe" hindered the county's ability to intervene in situations before they escalated into crises. One participant described "knocking at the door" for services but being told the situation was not severe enough. These findings reveal the potential for enhanced clarity of county behavioral health services eligibility criteria. Outreach and education about SMI services were also identified as growth areas. Stakeholders recommend reducing stigma among hospital staff, law enforcement, and the general public. Parents of children with SMI specifically requested that providers approach families as partners. Finally, participants requested enhanced education for families about diagnoses and available services.

SUBSTANCE USE DISORDER (SUD)

Substance use navigators, community health workers, telehealth options, County SUD screening clinics, and County contracted vendors were identified as program strengths. Participants described what they perceived to be limitations in SUD treatment for minors, with participants noting that youth have limited options if initial referrals are unsuccessful. These findings highlight the perceived need for youth SUD services and the potential to develop enhanced SUD services for minors that can serve a greater number of individuals. Geographic disparities were also perceived by participants, with Truckee described as "very underserved," and previous Spanish-speaking SUD services in Kings Beach having been discontinued. Stakeholders emphasized what they perceived as a need for education and stigma reduction around substance use, noting that stigma

affects both access to care and quality of treatment. The most frequent recommendation from participants was to establish a local detox center and expand residential treatment capacity. Participants also emphasized the potential to enhance the timeliness of services, highlighting the importance of "grab them when they are ready."

WORKFORCE

NCBH staff, case managers, volunteers, and leadership received widespread praise for compassion, collaboration, and effectiveness. The workplace culture was described as safe, healthy, and innovative. External partners reported positive collaboration experiences, and consumers noted that Nevada County offers more services than most counties. However, what participants perceived as staffing shortages were identified as an issue that participants thought affected service delivery across all programs. Participants described what they perceived as issues with staffing levels, which led to heavy caseloads and a perceived need for more timely services. Staff turnover, although perceived as lower than in other countries, was considered a barrier to continuity of care for families. The need for bilingual staff, particularly Spanish-speaking providers, was emphasized throughout the data.

APPENDIX 1 – STATEWIDE GOALS

Goals *in red* are goals in which the county is performing '*worse*' (i.e., higher or lower, depending on the goal) on one or more primary measures compared to the average of all California counties.

Priority Goals

- Access to Care
- Homelessness
- Institutionalization[2]
- Justice-Involvement
- Removal of Children from Home
- Untreated Behavioral Health Conditions

Additional Goals

- Care Experience
- Engagement in School
- Engagement in Work
- Overdoses
- Prevention and Treatment of Co-Occurring Physical Health Conditions
- Quality of Life[3]
- Social Connection[4]
- Suicides[5]

[2] Limited data available
[3] Performance on one primary indicator *negligibly* below state average
[4] Performance on one primary indicator *negligibly* below state average
[5] Performance on one primary indicator *negligibly* below state average

APPENDIX 2 – REQUIRED STAKEHOLDERS

A list of the required stakeholders, as presented in the Integrated Plan template, is provided in the table below.

Required Stakeholder/Group	Able to engage?	Reason not engaged?
Area agencies on aging	Yes	-
BHSA eligible adults and older adults	Yes	-
Community-based organizations serving culturally and linguistically diverse constituents	Yes	-
Continuums of care, including representatives from the homeless service provider community	Yes	-
County social services and child welfare agencies	Yes	-
Disability insurers	No	Attempted but did not receive a response
Early childhood organizations	Yes	-
Emergency medical services	Yes	-
Families of BHSA eligible children and youth, adults, and eligible older adults	Yes	-
Higher education partners	No	Attempted but did not receive a response
Health care organizations, including hospitals	Yes	-
Health care service plans, including Medi-Cal managed care plans	Yes	-
Independent living centers	Yes	-
Individuals with behavioral health experience, including peers and families	Yes	-
Labor representative organizations	No	Attempted but did not receive a response

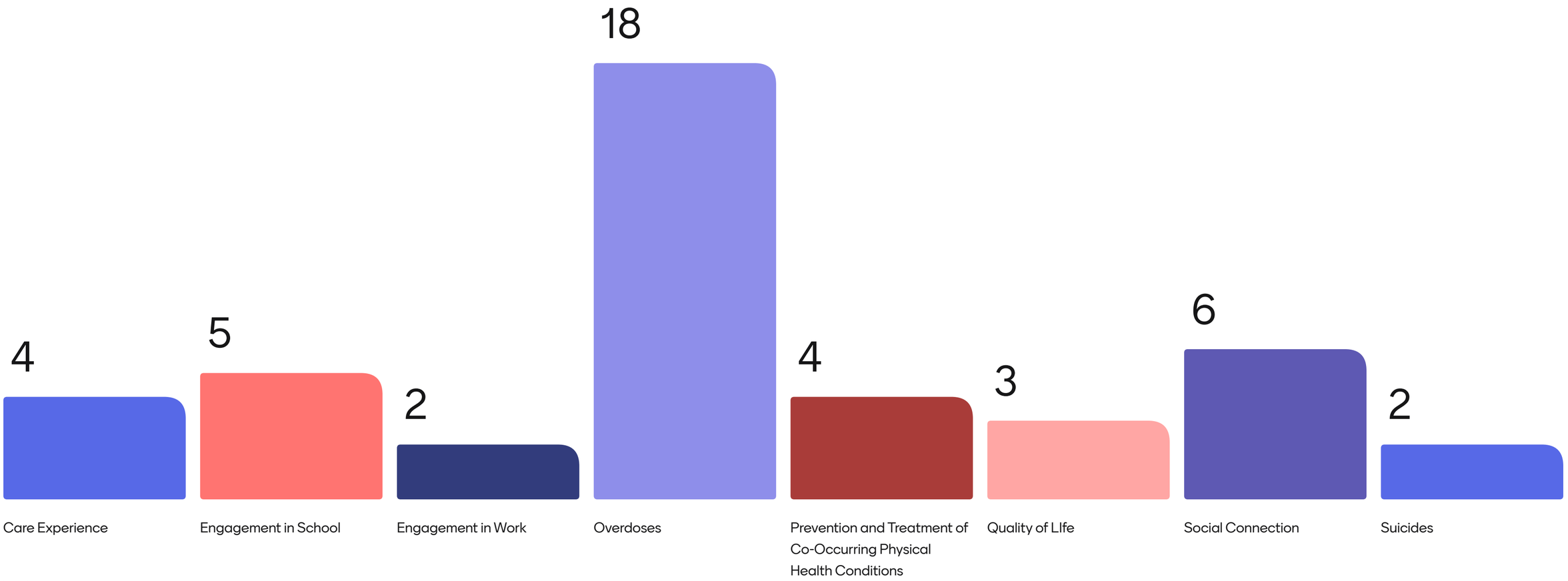
Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) communities	Yes	-
Local education agencies	Yes	-
Local public health jurisdictions	Yes	-
Organizations specializing in working with underserved racially and ethnically diverse communities	Yes	-
People with lived experience of homelessness	Yes	-
Providers of mental health services	Yes	-
Providers of substance use disorder treatment services	Yes	-
Public safety partners, including county juvenile justice agencies	Yes	-
Regional centers	No	Attempted but did not receive a response
The five most populous cities in counties with a population greater than 200,000	No	Stakeholder group is not applicable to county
Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes	Yes	-
Veterans and representatives from veterans' organizations	Yes	-
Victims of domestic violence and sexual abuse	Yes	-
Youth from historically marginalized communities	Yes	-
Youths (individuals with lived experience), youth mental health organizations, or youth substance use disorder organizations	Yes	-

APPENDIX 3 – ADDITIONAL SURVEY RESULTS

Table 11. Survey Respondents Agreement on Statements

Statements	Valid n	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Opinion or Don't Know
There are gaps in behavioral health education and wellness programming about behavioral health in my community.	95	1%	5%	13%	58%	19%	4%
My organization has provided me with adequate tools for providing services for diverse patients/clients in an inclusive way.	94	1%	0%	7%	49%	39%	3%
My organization utilizes remote/phone/video appointments with my clients/patients.	95	3%	4%	7%	40%	37%	8%
If a client/patient needed a higher level of care for their mental health, I know how and where to refer them.	94	3%	6%	5%	44%	38%	3%
If I refer a client/patient for a higher level of care for their mental health, I am confident that they will receive the services they need.	95	3%	26%	23%	32%	13%	3%
If a client/patient needed (additional) help with substance use services, I know how and where to refer them.	94	0%	7%	11%	46%	30%	6%
If I refer a client/patient for additional help with substance use services, I am confident that they will receive the services they need.	95	1%	18%	28%	34%	13%	6%
If a client/patient needed additional help with housing support, I know how and where to refer them.	94	1%	4%	16%	55%	20%	3%
If I refer a client/patient for additional help with housing support, I am confident that they will receive the services they need.	95	5%	17%	29%	38%	6%	4%
My organization provides an effective process for following up after referrals are made to NCBH when a client/patient needs additional help.	94	1%	10%	24%	35%	18%	12%

Which "additional" population health goal would you like BH to prioritize?



What solutions would you like to see to address homelessness and housing?

increased housing stock

2 Popular

Expand affordable housing, rental assistance, crisis and interim housing

2 Popular

Expand community-based supportive housing

1

youth transitional housing programs

1

safe parking options

1

Supportive services for people who are housed. more transitional housing, especially for youth safe parking options

1

Single point of entry, very obvious, to navigate services

1

Bridge gaps between services.

1

What solutions would you like to see to address homelessness and housing?

more transitional housing

accessible housing for those with co-occurring conditions

education on how to find housing, especially after finding a voucher

Expand community based supportive housing

safe parking for people living in their cars, some (don't know how many) with sub abuse or mental health problems.

Mental health stability, SUD support, and life skills/job readiness training

What solutions would you like to see to address overdoses?

A medically-assisted sobering center

3 Popular

harm reduction

2

More transitional housing after recovery residences

1

more residential treatment beds

1

look at interaction between homelessness and overdoses

1

early prevention

1

Peer support and recovery groups, harm reduction, housing

1

more detox resources

What solutions would you like to see to address overdoses?

education and stigma reduction

treatment beds for faster access

Robust stigma training

Housing the unhoused

Harm reduction approach

early interventions in schools

What solutions would you like to see to address client care experience?

Education on diagnoses

More bilingual therapists

more care coordinators

more peers

school based services that aren't restricted by insurance

warm handoff

What solutions would you like to see to address family experience?

more family engagement in treatment

Support Groups

helping clients escape from toxic families

flexible funds to help families with financial harships

Parent education on mental health & substance use at the elementary level.

What solutions would you like to see to address access to county behavioral health services and connection to care?

Clearer eligibility standards for county services

Communication back to referring party about referral outcomes/progress

more warm handoffs for referrals to care

walk-in access services

Walk-in hours for assessments

outreach

bringing services to participants

Timely appointment availability. No long wait times.

What solutions would you like to see to address transportation?

Dedicated bus route between county buildings

On demand ride service

Rely more on Partnership transportation services

volunteer drivers

Education on NEMT

direct service in the field

more reliable partnership transportation services (eastern county to down the hill specialty appointments specifically)

expanding bus route area to include "satelite stops" outside of city limits.

7

Mentimeter

What solutions would you like to see to address transportation?

Free on demand transportation between Truckee and CSU & back

210

7

What solutions would you like to see to address crisis services?

post-crisis follow ups

local 988 call center

expanded CSU bed capacity/broaden available services at the CSU

peer support

Peer Support or Case Management to assist with interim post-crisis care

giving participants directed access to trusted partners

Follow up from 988 calls & ED visits, 5150s using the caring connections model

Other Solutions?

Priority early education & prevention

art/expression based outreach

more advocacy for safe camps and parking

Behavioral Health Services Act (BHSA) Community Meeting

November 2025

NEVADA COUNTY
CALIFORNIA

Agenda

- Behavioral Health Services Act Overview
- Behavioral Health Needs Assessment
- Solutions Brainstorming Exercise
- FY 26/27 Fiscal and RFP Update

NEVADA COUNTY CALIFORNIA | Behavioral Health

Purpose of BHSA Community Meetings

- **Transparency & community voice**
- **Keep community & stakeholders informed about key BHSA updates:**
  - Education on BHSA and what it can fund/what it funds locally
  - Fiscal Updates
  - Programmatic & regulatory changes
  - Key priorities for BHSA expenditure
  - Sharing performance outcomes of funded programs
  - Input on planning and needs assessment process

NEVADA COUNTY CALIFORNIA | Behavioral Health

BHSA Overview

NEVADA COUNTY
CALIFORNIA

What is Behavioral Health Services Act (BHSA)?

- Formerly known as Mental Health Services Act (MHSA), funded by a 1% tax on personal income over $1 million per year in California
- Three Year Program Plan (FY 26/27 through FY 28/29) with Annual Updates to the Plan

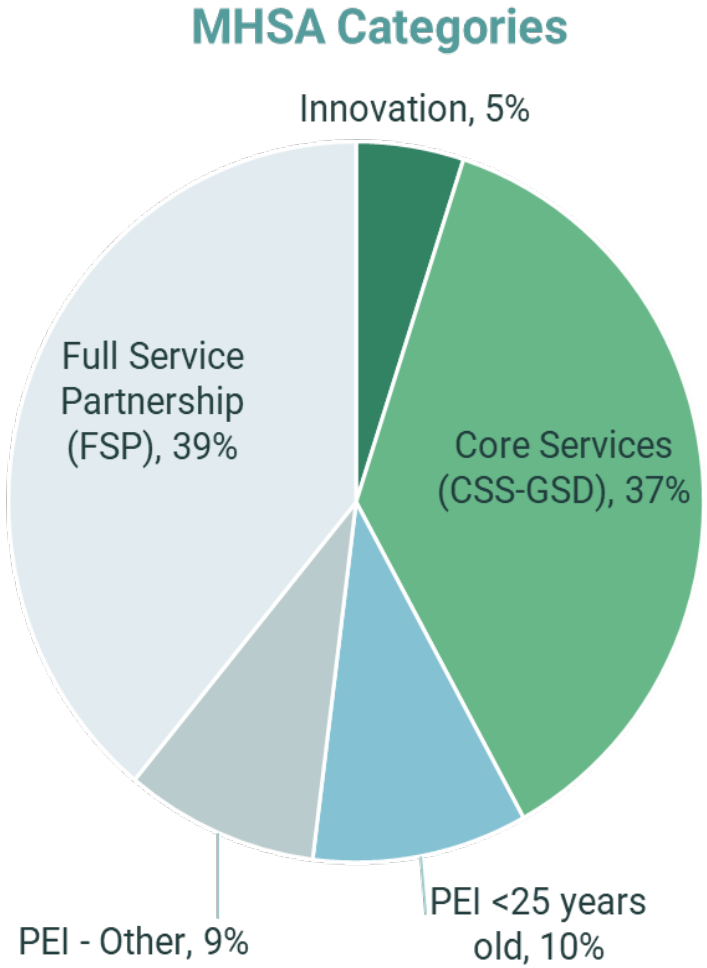
NEVADA COUNTY CALIFORNIA | Behavioral Health

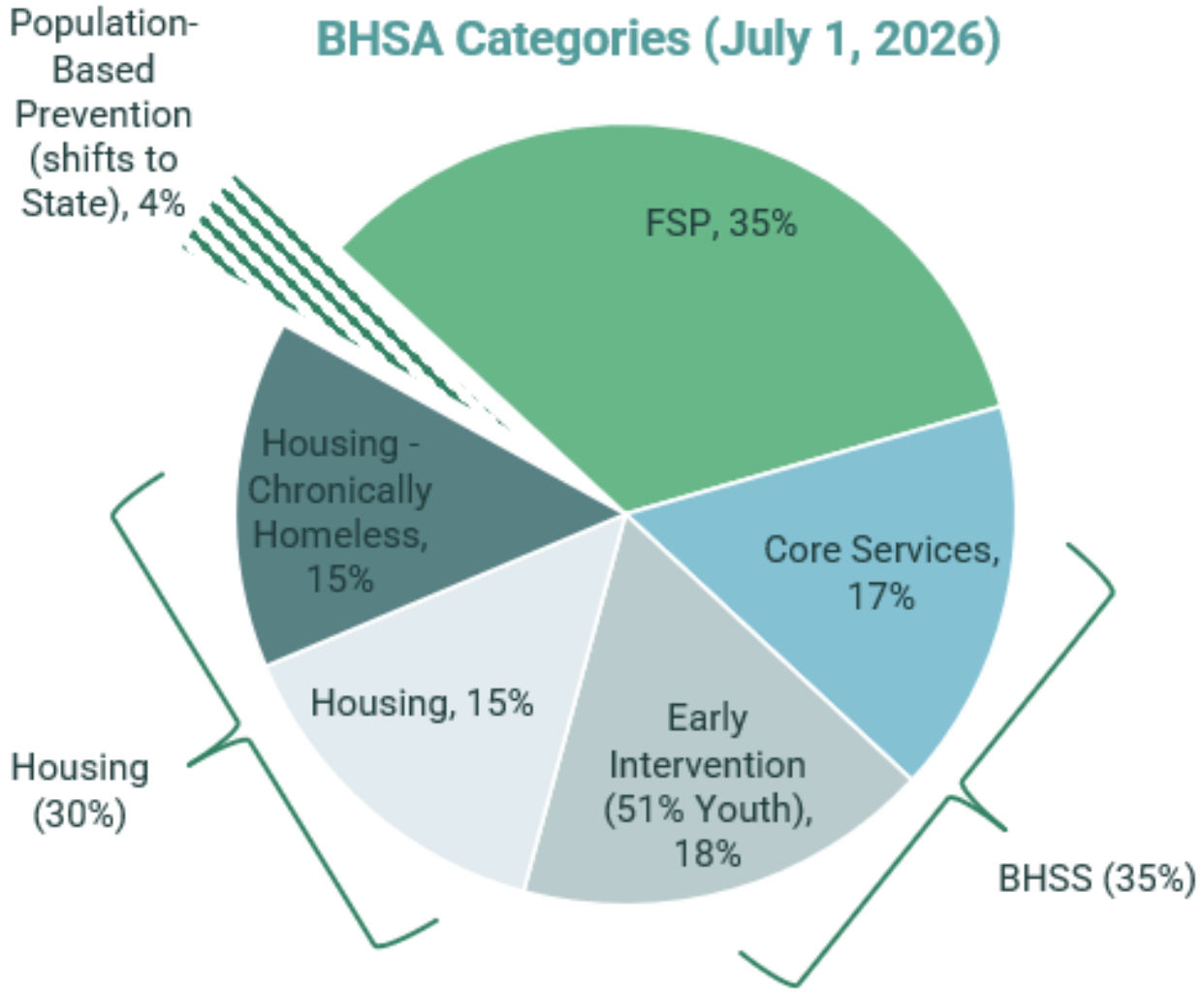
BHSA Key Changes

- New funding buckets, with emphasis on housing
- Expansion of BHSA to fund SUD services
- Broader state oversight over all BH funding including Integrated Plan approval
- Increased data and outcomes reporting and accountability to new population health goals
- Counties must maximize Medi-Cal dollars/billing prior to use of BHSA funds, when applicable

NEVADA COUNTY CALIFORNIA | Behavioral Health

MHSA VS. BHSA Categories





NEVADA COUNTY CALIFORNIA | Behavioral Health

BHSA Eligible Populations

- People with moderate to severe mental illness or moderate to severe substance use disorder who are Medi-Cal eligible
- Expansion of BHSA to be able to fund SUD services, but no new funding
- Moving toward a more integrated system between MH and SUD needs
- Population health prevention activities and stigma reduction now managed at the state level

NEVADA COUNTY CALIFORNIA | Behavioral Health

Behavioral Health Needs Assessment Overview

NEVADA COUNTY
CALIFORNIA

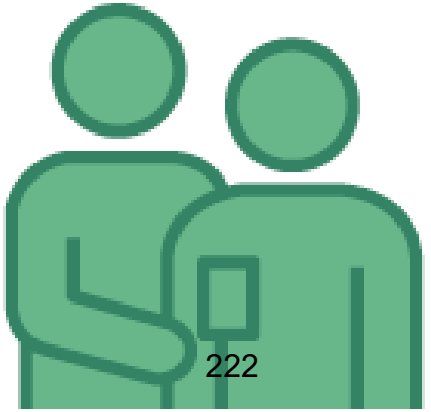
CPPP Background

Purpose:

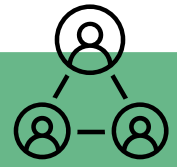
- Get **community input** on behavioral health services and funding
- Make sure **services match** what the community actually needs
- Build on **engagement** work already happening locally

Key Features:

- **Building Trust:** Creates stronger relationships between community and behavioral health system
- **Required Community Members:** Specific groups must be engaged in funding priority decisions



CPPP Participation Overview

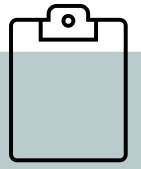


Focus Groups

- 210 individuals
- 16 groups

Key Informant Interview

- 8 interviewees



Stakeholder Survey

- 119 respondents

Geographic Coverage: Western Nevada County & Truckee/Eastern County

Languages: English and Spanish

Total Participants: 337

Qualitative Findings:

Focus Groups & Interviews

Focus Groups (16)

- Adult Mental Health Consumers (Western County)
- Adult Mental Health Consumers (Truckee)
- Mental Health and Substance Use Advisory Board
- Youth Consumers' Family Members
- Youth Consumer Providers
- Behavioral Health Providers
- NCBH All Staff Meeting
- Tahoe Truckee Providers
- Youth Early Intervention Providers
- Criminal Justice Partners
- Educators (West County)
- Health Care Providers
- Spanish Speaking Consumers in Truckee
- Spanish Speaking Providers in Truckee
- Unhoused
- Overdose Prevention Coalition

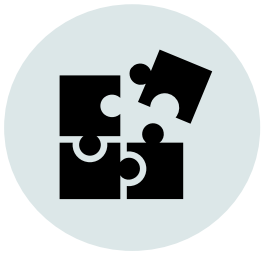
Key Informant Interviews (8)

- CHIRP
- Agency 4 Area on Aging
- FREED
- Bright Futures for Youth
- NC Pride
- Community Beyond Violence
- VSO
- NCSOS Promotoras

Crisis Services Feedback

Strengths

- Mobile crisis team effectiveness
- CSU (Crisis Stabilization Unit)
- Staff quality and communication
- Response to schools/hospitals



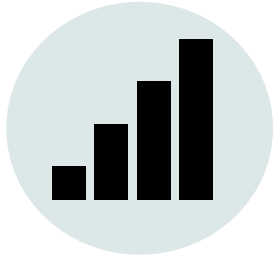
Gaps

- Response time concerns
- Follow-up after crisis intervention
- Crisis line staffing/customer service
- Limited CSU capacity (only 4 beds)
- 988 calls route to Sacramento, not locally

Recommendations

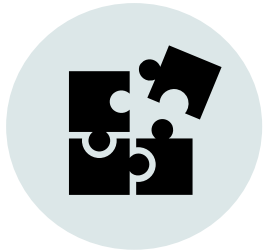
- Expand CSU bed capacity
- Establish local 988 call center
- Increase crisis line staffing
- Create a centralized resource directory
- Enhance law enforcement training
- Improve follow-through protocols

Crisis Services Quotes



Strengths

- *“Mobile crisis team is working well and maintains good communication with staff.”*
- *“Mobile Crisis Team is an asset” and “CSU is a strength.”*
- *“Having a mobile crisis team at the hospital is working really well…[they have] the direct ability to respond.”*



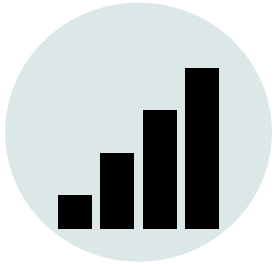
Gaps

- *"Response time isn't as quick but haven't had to call them in a while.“*
- *“No follow up or sustained support after crisis.”*
- *“Crisis line seems overburdened” and “not enough time to talk.”*

Recommendations

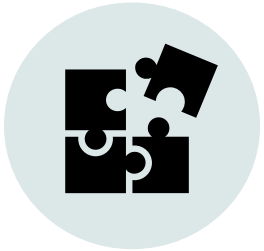
- *"A more robust Crisis Stabilization Unit (CSU) is needed for overnight stays; currently there are about four beds, and not everyone meets the criteria to stay.“*
- *"Would like a local 988 call center -- understanding is that 988 calls go to Sacramento right now."*

Housing Feedback



Strengths

- Home Team Outreach
- Specific Programs: Hospitality House, Spirit Center, Sierra Community House, Stagecoach Project, FREED



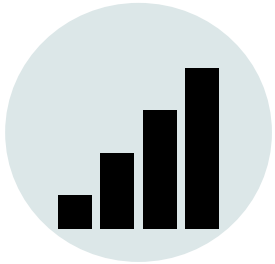
Gaps

- Long waitlists (2-3 years for some housing programs)
- Excessive documentation requirements before placement
- Coordination issues
- Issues with transitional and youth housing/shelters
- No pet-friendly options

Recommendations

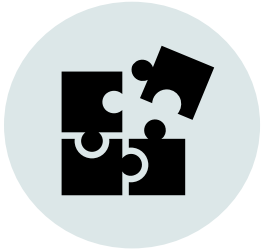
- Expand community-based supportive housing with wraparound services
- Increase longer-term funding for transitional housing and capacity
- Youth transitional housing programs
- Accessible housing for those with SMI/SUD/co-occurring conditions
- Improve voucher system

Housing Quotes



Strengths

- *"Home team's outreach and engagement efforts have increased client involvement when they do connect with services."*



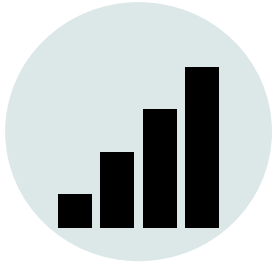
Gaps

- *"Been on the waiting list for apartments for less than a year - doesn't matter if you have a full-time job within two weeks of getting out of jail, still homeless.“*
- *"Finding housing is a joke" and there were no "temporary place[s] to sleep at night in Truckee."*

Recommendations

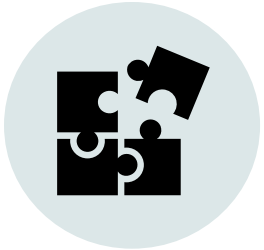
- *“Have patients who finally get a voucher and 60 days to find a landlord. Maybe a community support process/training on how to find housing even after receiving a voucher. For those with pets, lack of capacity. Not enough housing.”*
- *"More transitional and permanent affordable housing" and "youth transitional housing.“*

Severe Mental Health Illness (SMI) Services Feedback



Strengths

- Case manager quality
- TTUSD Wellness Centers
- Tahoe Forest Hospital System
- Odyssey House
- Service quality and staff experience



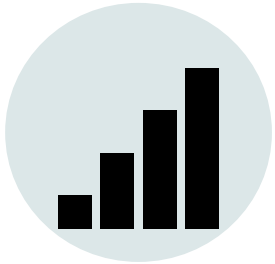
Gaps

- Definition of “severe” prevents early intervention
- Issues with outreach/education about SMI services
- Stigma from hospital staff, law enforcement, public against those with SMI

Recommendations

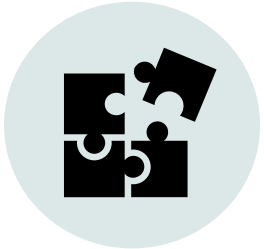
- More clarity around eligibility criteria for county behavioral health services
- Reduce SMI stigma through training (hospital staff, law enforcement, public)
- Partner with families as part of the solution, not as part of the problem
- Education for families about diagnoses and living with SMI
- Involve parents in treatment planning

Severe Mental Health Illness (SMI) Services Quotes



Strengths

- *"County is doing a good job for SMI.“*
- *"They are very busy and often overwhelmed, but they really do work well together.“*
- *"Case managers are doing a fabulous job."*



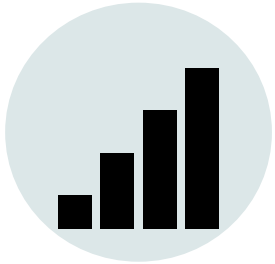
Gaps

- *“The word is severe. What defines severe? This word 'severe' seems to rule the world. What seems severe to you might be different from what I look at.”*
- *“I’m knocking at the door for help before things get worse but the gate is still closed.”*
- *"I have to prove how severe it is...I know what's going on, I know the signs, why won't you help me?"*

Recommendations

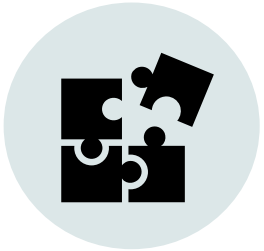
- *"Parents could be a huge part of the solution if they were educated and approached properly.“*
- *"More focus on education on diagnosis, understanding your own diagnosis and how to live with it.“*

Substance Use Disorder (SUD) Services Feedback



Strengths

- Substance use navigators
- Community health workers
- Telehealth options
- County SUD screening clinics
- County contracted providers



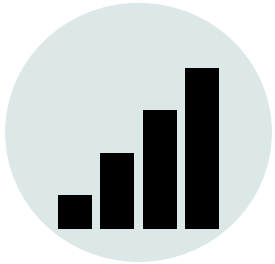
Gaps

- Services for minors/youth
- Geographic disparities – Truckee is “very underserved”
- No youth SUD screening tool available (only adults)
- Access to residential treatment beds

Recommendations

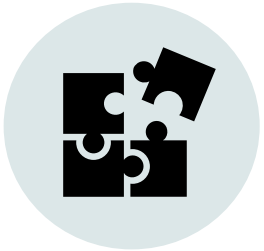
- Need for more education and stigma reduction around SUD
- Need for a Detox Center
- Need for expanded Residential Care
- More/enhanced substance use services for youth

Substance Use Disorder (SUD) Services Quotes



Strengths

- *Participants discussed substance use navigators, community health workers, “telehealth options,” and “County SUD screening clinics” as strengths of SUD services.*



Gaps

- *"Low-barrier SUD treatment for youth is needed.“*
- *"Gap in services for youth and youth with SUD...[youth have] two options and if neither of those options work out" they have no more options.*
- *"Truckee [is] very underserved" and "geographic limitations."*

Recommendations

- *"[Need to] address both training and stigma through one training.“*
- *"[Need a] way to make it common knowledge for youth to easily access substance abuse services.“*
- *"Lack in detox centers, and it is difficult to get into the beds.“*
- *"Need for sobering centers and residential treatment beds.”*

Workforce Feedback

Strengths

- Staff compassion and collaboration were highly praised
- Strong leadership
- Safe, healthy work culture
- Strong case managers

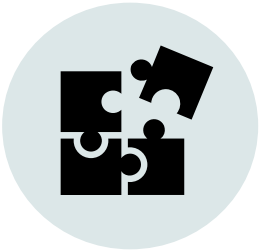
Gaps

- Critical staffing shortages affecting all service domains
- Heavy caseloads leading to access challenges
- Turnover creates barriers for clients seeking continuity of services

Workforce Quotes

Strengths

- *“State board has said Nevada county is one of most collaborative in the state”*
- *"[NCBH] offers more than most counties. [They] are already doing a fantastic job already between psychiatrists, peer support people, therapists doing fantastic job with what they have."*



Gaps

- *"Not enough behavioral health workers...NCBH should double the number of people helping out their clients.“*
- *"There's just so much turnover it's become quite the barrier to families receiving services."*

Stakeholder Survey

Selected Findings

Survey Highlights - Demographics

Key Demographics of Respondents

- 71% work in Mental/Behavioral Health
- 88% affiliated with NCBH & 56% community partners

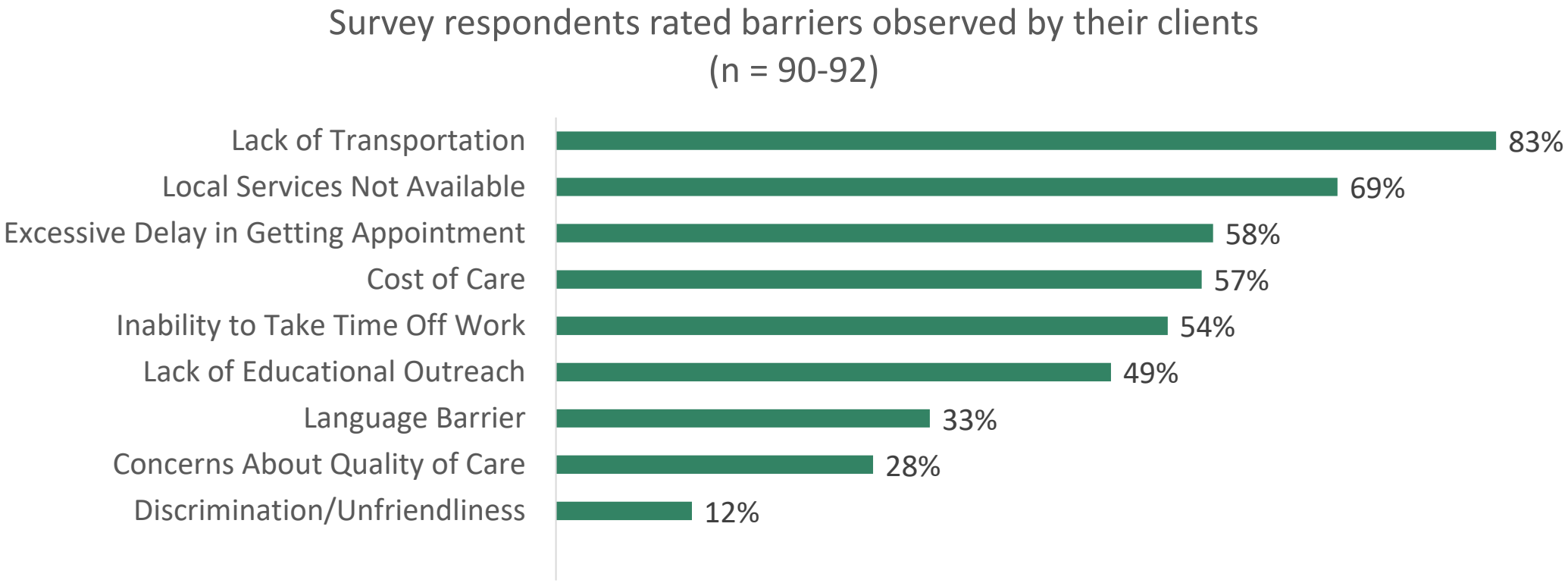
Age Groups Served

- 64% Adults (26-64)
- 20% Youth/Transitional Age Youth (12-25)
- 4% Older Adults (65+)
- 12% Children (0-11)

Priority Populations Served by Respondent

- 68% at risk of or chronically experiencing homelessness
- 57% at risk of, in, or exiting justice system
- 35% at risk of institutionalization
- 29% at risk of conservatorship

Barriers to Accessing Behavioral Health Care



Key Insight:

Access challenges are more structural and systemic (transportation, availability, wait times) rather than interpersonal or quality-related issues (discrimination, language, quality concerns).

If I refer a client/patient for additional help with [category], I am confident they will receive the services they need

% of Strongly Agree and Agree Responses
(N = 95)

Service Category	% Strongly Agree and Agree
Mental Health	44%
Substance Use	47%
Housing	44%

Providers lack confidence that clients will receive necessary services after a referral. Less than half of the respondents strongly agree or agree that they are confident.

Priority Improvement Areas Themes

Question: *"What is the most important thing that behavioral health organizations could do to improve the quality and availability of behavioral health care in the area?" (N = 66)*

Care Coordination	Staffing Challenges	Housing	Program Improvement	Transportation
Simplify system navigation for clients and providers	Competitive pay and manageable caseloads to improve retention	Emphasis on supportive housing with wraparound services	Better educational outreach and awareness	Significant barrier in rural Nevada County
Create close-loop referrals and consistent eligibility standards	Need for bilingual and culturally competent staff	Transitional housing with longer stays	Upstream prevention and early intervention	Limits access to all behavioral health services
Improve collaboration across agencies	Specific need for Spanish-speaking providers	Access challenges create critical gaps	Insurance coverage gaps - need for services for those with private insurance or no insurance (not just Medi-Cal)	

Priority Improvement Area Quotes

Question: *"What is the most important thing that behavioral health organizations could do to improve the quality and availability of behavioral health care in the area?" (N = 66)*

Care Coordination (32%)

*"...make the system easier to navigate for both clients and partners. This means **clearly communicating eligibility requirements, creating consistent and transparent standards for accessing services, and ensuring closed-loop referrals** so that providers and frontline workers know when their clients have successfully connected."*

Housing (17%)

*"Transitional housing for the **gap between residential treatment and for those who cannot/will not utilize the shelter.** Limited affordable housing resources overall."*

*"Provide supportive housing options for **TAY youth** transitioning off probation, or out of Child Welfare or guardianship."*

Staffing (17%)

*"Maintain full staffing of case managers. Build more **Peer Support** for SUD and MH services--especially SUD. Closely monitor contract provider service provision. Increased outreach services and housing availability."*

Program Improvement (14%)

"Have the availability to take anyone who is suffering from moderate to severe mental health problems regardless if they have Med-Cal, private insurance or no insurance."

Behavioral Health Transformation/ Population Health Indicators

Priority Goal Indicators

Goal	Better *(than state)*	Worse *(than state)*
Access to Care	**SMHS Penetration Rate – Adults, Children/Youth** **NSMHS Penetration Rate – Adults, Children/Youth** **DMC-ODS Penetration Rate – Adults, Children/Youth**	Initiation of SUD Treatment
Homelessness	**Public School Students Experiencing Homelessness** Ppl Exp Homelessness accessing COC services	**People Experiencing Homelessness** Ppl Exp Homelessness with SMI Ppl Exp Homelessness with Chronic SA
Institutionalization	SMHS Crisis Stabil., Hrs per – Adults	SMHS Crisis Interv., Min per – Adults SMHS Crisis Interv., Min per –Children
Justice Involvement	**Arrests - Adults** Adult Recidivism Conviction Rate Incompetent to Stand Trial	**Arrests - Juveniles**
Removal of Children from Home	**Children in Foster Care** Child Maltreatment Substantiations	Open Child Welfare Cases – SMHS Penetration
Untreated Behavioral Health Conditions	**Follow up after ED Visit for Substance Use** **Follow up after ED Visit for Mental Illness** Adults who expressed Behavioral Health needs who did not access services	

Primary indicators are **bolded and underlined.**

Underperforming Priority Goal: Homelessness

	Indicator	Nevada County	State (CA)
Primary	Point-In-Time (PIT) Rate of People Experiencing Homelessness (Rate per 10,000)	50.6	48.0
Primary	Percent of K-12 Public School Students Experiencing Homelessness	3.8%	5.3%

Key Findings:

- Nevada County's overall homelessness rate is **slightly higher** than state average.
- Student homelessness is **lower** than state average.
- Despite mixed performance on primary indicators, community feedback emphasized housing as the most critical need across all stakeholder groups.

Community Voice

"The housing situation is dire. There are no places for them to go."

Underperforming Primary Indicator: Juvenile Arrests

Goal: Justice Involvement

	Indicator		Nevada County	State (CA)
Primary	Arrests (Rate per 100,000)	Adult	1,996.0	2440.2
		Juvenile (*under 18*)	583.4	371.5

Key Findings:

- Nevada County's juvenile arrest rate is 1.6 times **higher** the state average.
- In contrast, adult arrest rate is **lower** than state average.
- This disparity suggests specific challenges or enforcement patterns affecting youth populations in Nevada County.

Community Voice

"Attendance is an issue for students with homelessness, even if schools try to provide services...they need a case worker."

Primary Indicator: ED Visits

Goal: Untreated Behavioral Health Conditions

	Indicator	Nevada County	State (CA)
Primary	Follow-up after Emergency Department Visit for Substance Use (FUA-30)	45.2%	28.8%
Primary	Follow-up after Emergency Department Visit for Mental Illness (FUM-30)	48.0%	38.2%

Key Findings:

- Nevada County outperforms the state on both primary indicators.
- Follow-up rate for substance use is 1.6 times the state rate.
- Follow-up rate for mental illness is 1.3 times the state rate.
- Strong performance indicates effective crisis-to-care linkages despite high overdose rates.

Community Voice

"No follow-up or sustained support after crisis...follow-up could be more seamless, especially during late-night hours."

Additional Goal Indicators

Goal	Better *(than state)*	Worse *(than state)*
Care Experience		Adult Perception of Cultural Appropriateness Youth Perception of Quality Quality Domain Score (Adults)
Engagement in School		12 graders graduating HS on time Chronic absenteeism Meaningful participation in school
Engagement in Work	Unemployment rate Unable to Work Due to Mental Problems	
Overdoses		All Drug-Related Overdose Deaths, Rate All Drug-Related Overdose ED Visits, Rate
Prev & Trt of Co-occurring Physical Health Conditions	Diabetes Screening - Ppl Using Antipsychotics	Adult Access to Preventive/Amb Care Service Child/Adolescent Well-Care Visit Metabolic Monitoring – Child on Antipsychotics
Quality of Life		Youth Perception of Functioning Adult Perception of Functioning Poor mental health days reported
Social Connection	Youth Perception of Social Connectedness	Adult Perception of Social Connectedness Caring Adult Relationships at School
Suicides		Deaths Non-fatal ED Visits from Self-Harm

Underperforming Additional Goal: Overdoses

	Indicator	Nevada County	State (CA)
Primary	**All Drug-Related Overdose Deaths** – Full Population (Rate per 100,000 – 2023 CDPH)	**48.3**	28.8
Supplemental	All Drug-Related Overdose Emergency Department Visits – Full Population	263.4	143.8

Key Findings:

- Nevada County's overdose death rate **is 1.7 times** the state average.
- Emergency department visits for overdoses are **1.8 times** the state average.
- Both indicators show significantly lower performance than the state level, indicating a critical need for expanded SUD services and harm reduction programs.

Community Voice

"There just are not enough treatment or detox facilities…Got to grab them when they are ready for change."

Poll on Additional Goals

Menti.com – use code 4789 3669

Goal	Better *(than state)*	Worse *(than state)*
Care Experience		**Adult Perception of Cultural Appropriateness** **Youth Perception of Quality** **Quality Domain Score (Adults)**
Engagement in School		**12 graders graduating HS on time** Chronic absenteeism Meaningful participation in school
Engagement in Work	**Unemployment rate** Unable to Work Due to Mental Problems	
Overdoses		**All Drug-Related Overdose Deaths, Rate** All Drug-Related Overdose ED Visits, Rate
Prev & Trt of Co-occurring Physical Health Conditions	Diabetes Screening - Ppl Using Antipsychotics	**Adult Access to Preventive/Amb Care Service** **Child/Adolescent Well-Care Visit** Metabolic Monitoring – Child on Antipsychotics
Quality of Life		**Youth Perception of Functioning** **Adult Perception of Functioning** Poor mental health days reported
Social Connection	**Youth Perception of Social Connectedness**	**Adult Perception of Social Connectedness** Caring Adult Relationships at School
Suicides		**Deaths** Non-fatal ED Visits from Self-Harm

Reflection

- What surprised you?
- What resonated?
- What felt most urgent to address?

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Solutions Brainstorming

What solution(s) would you like to see to address each need?

- If you see a solution you like on the board, put a “dot” sticker next to it
- If you have an idea not on the board, write it on a Post-It and stick it on!
- Be specific – i.e. “Care coordinator to walk someone through the access process” instead of “more care coordination”

NEVADA COUNTY CALIFORNIA | Behavioral Health

FY 26/27 Fiscal Picture and Request For Proposal (RFP) Timeline

NEVADA COUNTY
CALIFORNIA

Fiscal Picture

- **Looking at whole funding picture, not just BHSA**
- **Nevada County ahead of the game in BH investments in housing and Medi-Cal billing**
- **Working hard to minimize funding cuts**
- **Early intervention largest potential area of change, but still will have funds for RFP**
  - Innovation project overview

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Housing

- **NCBH currently funds:**
  - 106 permanent housing units
  - 148 interim housing units (97 recovery residence beds and 46 BHBH beds, 5 TP beds)
  - 6 beds of Board and Care/long term housing
  - Additional 24-40 units coming online in coming years with Homekey+ projects
- **No plans to RFP housing this year**
- **Unknown federal impacts – roughly $225K of federal funding at risk**

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RFP Buckets (Tentative)

- Crisis Services
- Adult FSP
- Youth Outpatient (including High Fidelity Wraparound)
- Homeless Outreach
- SUD Outpatient and Recovery Residences
- Early Intervention

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Tentative RFP Timeline

December 10, 2025	RFP release for 26/27 funding
December 29 or January 5	Pre-proposal Conference/Q&A
January 19, 2026	RFP closes

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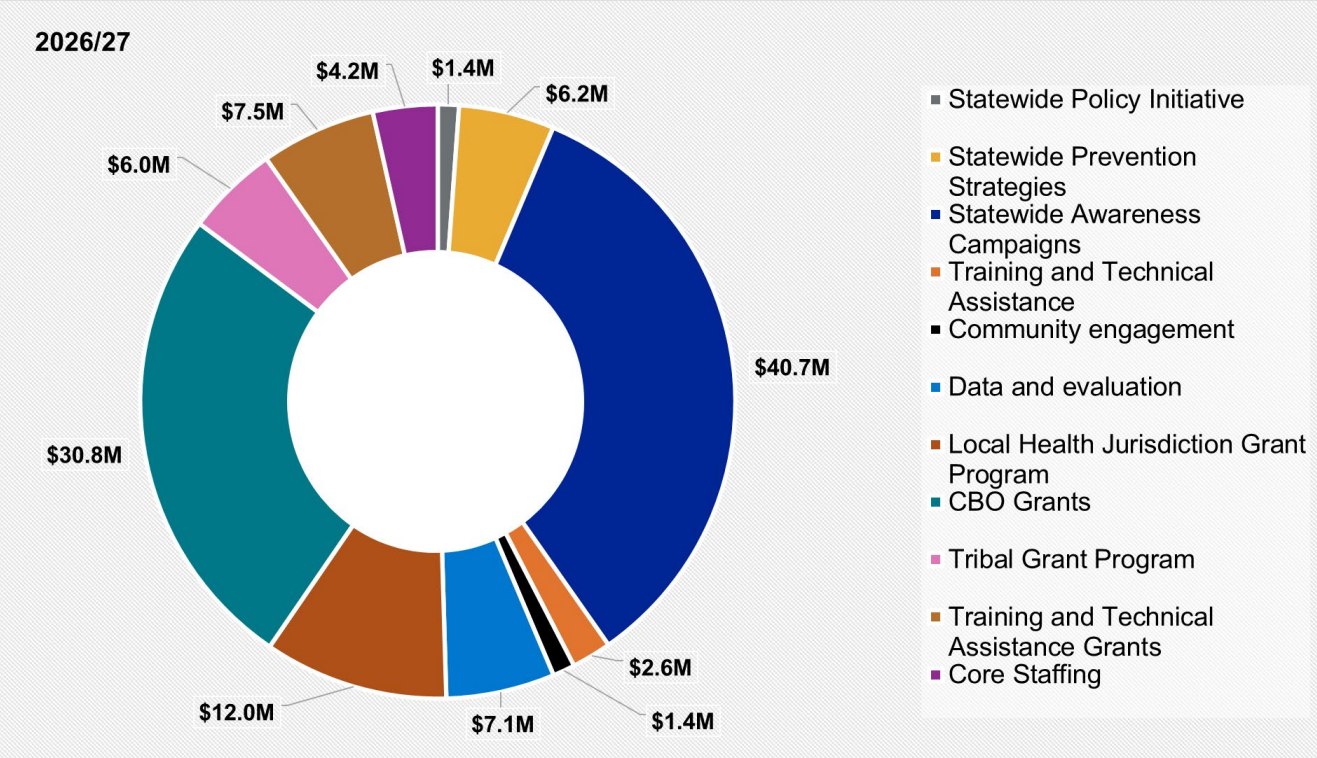
CDPH Population-Based Prevention Program

- Program Guide currently out for public comment - https://www.cdph.ca.gov/Programs/OPP/Pages/Engagement.aspx
- Likely future statewide RFPs through CDPH for specific prevention strategies



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Quality Improvement Work Plan

Mental Health and Substance Use Disorder Services

2026

February 2026

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I. Quality Improvement Program Overview

A. Program Characteristics

The function of the Nevada County Behavioral Health (NCBH) integrated Quality Improvement (QI) Mental Health (MH) and Substance Use Disorder (SUD) Work Plan (referred to as the "NCBH QI Work Plan" throughout this document) is to plan and monitor compliance with the program goals regarding access to services, improvements to service delivery, and enhancements to quality of care. This purpose is accomplished by following a planned and systematic process of collecting data, setting objectives, and monitoring both progress and need to implement novel interventions or changes to the system, thereby contributing to continuous quality improvement.

Evaluating and Monitoring quality improvement, compliance activities, and consumer rights issues occurs through regular management oversight, as well as through the Quality Improvement Committee (QIC) and Compliance Program Committee reviews. Other sources of Feedback are also obtained through the following:

- Consumer, youth, and family surveys
- Utilization review activities
- Chart audits
- Review of electronic record or Share Point Dashboards specific to data analysis
- Medical peer review
- Regular QIC and Compliance Program Committee meetings
- Cultural Competency Committee meetings
- Management meetings
- Mental Health Board (MHB) review
- Review of consumer and provider grievances and appeals
- Review of special or unusual occurrence incidents
- Periodic clinical training

The NCBH QI Work Plan includes activities required by the Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS) for the provision of Medi-Cal Specialty Mental Health Services; and the Intergovernmental Agreement between NCBH and the California Department of Health Care Services (DHCS) for the provision of Drug Medi-Cal substance use treatment services. QI projects, whenever possible, incorporate the processes outlined in the agreements between NCBH and DHCS. These processes include:

- Collecting and analyzing data to measure access, quality, and outcomes, against goals or identified prioritized areas of improvement,
- Identifying opportunities for improvement and determine which opportunities to pursue,
- Designing and implementing interventions to improve its performance,
- Measuring the effectiveness of interventions, and
- Integrating successful interventions in the service delivery system, as appropriate.

It is the goal of NCBH to build a structure that ensures the overall quality of services. This goal is accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumers and family members; and utilization of technology for data analysis. Through data collection and analysis, significant trends are identified, and policy and system-level changes are implemented when appropriate.

With the California Medi-Cal Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC ODS) service delivery systems landscape beginning to change because of DHCS driven California Advancing and Innovating Medi-Cal (CalAIM) initiatives, NCBH has also begun to implement a greater range and variety of quality management and quality improvement activities. Some of these QI initiatives and program implementations have their own independent work plans or project management teams (such as the Behavioral Health Quality Improvement Program: CalAIM package) or the new electronic health record system, which was implemented on July 1st, 2023. However, because of their impact and inclusion in overall NBCH QI activities, they will also be reviewed in this work plan where appropriate and goals/activities relevant to them.

Other impacts to Quality Assurance (QA)/QI activities and implementations also include newly developed or implemented Behavioral Health Information Notices (BHINs), which are posted by DHCS and immediately impact services provision or regulatory oversight, and which QI must respond to at both a systems and programmatic level to maintain compliance within the delivery systems.

B. Quality Management Committees

Essential to the performance of the QI program is a complete information feedback loop wherein information flows across clinical, programmatic, and administrative channels. NCBH has established two committees, the Quality Improvement Committee and the Compliance/Utilization Management Committee, that include representation from the MHP and DMC ODS (licensed MH and licensed/ or certified SUD clinicians, management, etc.), organizational providers, consumers, family members, and stakeholders, to ensure the effective implementation of the QI Work Plan and activities. These committees are involved in the following functions:

1. The Quality Improvement Committee (QIC) is charged with implementing and reviewing the quality improvement activities of the agency. Monthly, the QIC collects, reviews, evaluates, and analyzes data and implements actions that frequently involve handling information that is sensitive and confidential. The QIC also provides oversight to QI activities, including the development and implementation of the Performance Improvement Projects (PIPs) as well as development of novel areas for improvement on the NCBH Project Tracker. The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs. The QIC documents all activities through dated agendas and minutes to reflect all QIC decisions and actions. Beginning during the Covid 19

pandemic and also due to the ability to utilize technological advances in communication, the monthly QIC meeting is held virtually through a Health Insurance Portability and Accountability Act (HIPAA) compliant virtual platform, which has brought both benefits and challenges. Via the virtual format the QIC is making efforts to increase community attendance.

The QIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the PIPs. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time, through both reports and the NCBH project tracker. The QIC continuously conducts planning and initiates new activities for sustaining improvement. Specific responsibilities of the QIC include, but are not limited to, the following:

- Review quality of care concerns
- Collect and analyze consumer survey responses
- Be a resource to individual programs
- Report data collection and outcome monitoring activities to Behavioral Health to improve system performance
- Plan, develop, and implement PIPs
- Review and update the Implementation Plans for SMHS and DMC-ODS
- Review and recommend action regarding issues involving:
    - Timely access to services
    - High-risk and individuals with high utilization of services
    - Unresolved clinical issues
    - Unresolved complaints
    - Evidence of treatment that is not within professional or ethical standards
    - Denials of service
    - Treatment that appears to be inadequate or ineffective
    - Utilization of inpatient and Institution for Mental Diseases (IMD) services
- Identify and address systems issues
- Monitor grievances and appeals
- Promote consumer and family voice to improve wellness and recovery
- Develop strategies to integrate health and behavioral health care throughout Nevada County
- Review Pathways to Wellbeing/Continuum of Care Reform (CCR) service activities and assess outcomes
- Disseminate communications to stakeholders regarding QI/QA initiatives and activities
- Provider QI/QA related trainings or information on updated policies

Designated members of the QIC include the Quality Assurance Manager; clinical staff; case management staff; management team staff, administrative staff; clients; family members; and other stakeholders. Members sign a Confidentiality Statement to insure the privacy of protected health information. This confidentiality statement is integrated into the QIC agenda, which is sent out in

advance of the meetings and shown at the beginning of each meeting.

NCBH procures contracts with individual, group, organizational providers, SUD treatment providers and for psychiatric inpatient care. As a component of these contracts, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by State and Federal laws. Each community based organization or contractor is expected to have a representative at the meeting, including a representative who can report out on agency specific data.

2. The Compliance Committee is charged with ensuring that Medi-Cal and Drug Medi-Cal services are billed appropriately and in compliance with all state and federal regulations. Please refer to the *NCBH Compliance Plan* for the roles and responsibilities of this committee.

C. Annual Work Plan Components

The NCBH QI Work Plan provides the blueprint for the quality management functions designed to improve both client access and quality of care. This Plan is evaluated annually and updated as necessary.

The NCBH QI Work Plan includes the following components:

1. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;
2. Objectives and activities for the coming year;
3. Previously identified issues, including tracking issues over time; and
4. Activities for sustaining improvement.

The most recent QI Work Plan is posted on the NCBH website, the NCBH QA SharePoint Website, and is available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the NCBH system. The QI Work Plan and QI Work Plan evaluations are also available to auditors during the triennial Medi-Cal review.

This Quality Improvement Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the QI Program. QIC members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The NCBH QI Work Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent specialty mental health and substance use disorder services.

II. Quality Improvement Program Evaluation

A. Evaluation of Overall Program Effectiveness

Evaluation of the overall effectiveness of the QI program is accomplished routinely, as well as annually, to demonstrate that:

- QI activities have contributed to improvement in clinical care;
- QI activities have contributed to timely access to services;
- QI activities have contributed to improvement in client services;
- QI activities are supporting regulatory compliance and implementation of required initiatives;
- QI activities have been completed, or are in process; and
- QI activities have incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services.

B. Specific Evaluation Activities

1. Quality Improvement Committee (QIC): The monthly virtual QIC meetings may include, but are not limited to, the following agenda items:
    - Review reports to help identify trends in client care, in timeliness of treatment plan submissions, services, and trends related to the utilization review and authorization functions;
    - Review and evaluate summary results of QI activities, including progress on the development and implementation of four (4) Performance Improvement Projects (PIP) (2 for MH and 2 for SUD);
    - Review data from Access Logs and 24/Hr. Test Call Reports showing responsiveness of the 24-hour member access line and for services in the prevalent non-English languages
    - Timeliness of first initial contact to face to face appointments or synchronous video or audio-only interaction, consistent with BHIN 23-018 or any subsequent Departmental guidance; responses to urgent conditions; and access to after-hours care;
    - Frequency of follow-up appointments;
    - Strategies to reduce avoidable hospitalizations;
    - Review data from Inpatient/IMD/Residential programs relating to census, utilization, and lengths of stay;
    - Review number, percent, and timeliness of DMC-ODS authorization requests that are denied;
    - Review summary data on the medication monitoring process to assure appropriateness of care, supervised by person licensed to prescribe or

dispense prescription medications;

- Review Pathways to Wellbeing/CCR services to show program implementation;
- Review number of children in placement, level of care, and changes in placement at least quarterly
- Review new Notices of Adverse Benefit Determination (NOABDs), focusing on their appropriateness and any significant trends;
- Review trends in change of provider requests;
- Review summary data from Utilization Review authorization decisions (child, adult and SUD charts completed monthly by supervisors and/or designee) to identify trends in client care, timeliness of services, trends related to utilization review and authorization functions, and compliance with documentation requirements.
- Assess member experience, including satisfaction surveys results for assuring access, quality, and outcomes.
- Review any issues related to grievances and/or appeals. The QIC reviews the appropriateness of the NCBH response and significant trends that may influence policy- or program-level actions, including personnel actions;
- Review any requests for State Fair Hearings, as well as review of any results of such hearings;
- Review any provider appeals and satisfaction surveys;
- Review client and system-level performance outcome measures for crisis, adults, and children to focus on any significant findings and trends;
- Review other clinical and system-level issues of concern that may affect the quality of service delivery. The information reviewed also allows the QIC to evaluate trends that may be related to culturally-sensitive issues and may require prescriptive action;
- Review potential or required changes in policy;
- Review the annual credentialing process to assure that all licensed staff follow their licensing requirements;
- Review annual reports regarding QI review of the Office of Inspector General's Exclusion List and the Medi-Cal List of Suspended or Ineligible Providers lists, prior to Medi-Cal certification of any individual or organizational provider, other federal lists; and;
- Review HIPAA compliance issues or concerns;
- Review cultural competency issues or concerns;
- Monitor issues over time and make certain that recommended activities are implemented, completing the Quality Improvement feedback loop;
- Review coordination of physical, mental health and SUD services with waiver services at the provider level; and
- Monitor number of days to first DMC-ODS service at appropriate level of care after referral, including timeliness of the first dose of Narcotic Treatment Program (NTP) services.
- Provision of any specific QI/QA trainings as necessary

2. Management Team Monthly Data Review: The NCBH Management team reviews key compliance, QA, and performance data monthly. The items discussed in the monthly meetings are determined by a data calendar informed by the NCBH Compliance Plan, QI Plan, Cultural Competency Plan, and other identified key performance metrics. This Management team data review assures compliance with state and federal regulations around documentation and billing through various monitoring activities. The goals of the UM Program are to ensure that: a) MH and SUD services are medically necessary and provided at the appropriate level of care; b) MH and SUD services are provided in a timely manner; c) available resources are utilized in an efficient manner; and d) admission criteria, continuing stay criteria, and discharge planning criteria are used to assure that maximum benefit is obtained by consumers at each level of care, and that transitions between levels of care and program services occur in a coordinated manner.

3. Monitoring Previously Identified Issues and Tracking over Time: Minutes of all QIC meetings include information regarding:
    - An identification of action items;
    - Follow-up on action items to monitor if they have been completed;
    - Assignments (by persons responsible); and
    - Due date.
    - Reports, handouts, or materials relevant to action items

    To assure a complete feedback loop, completed and incomplete action items are identified on the agenda for review at the next meeting. NCBH has developed a meeting minute template to ensure that all relevant and required components are addressed in each set of minutes. Meeting minutes are also utilized to track action items and completion dates.

    Due to the diverse membership of the QIC and Compliance/Utilization Review Committee, information sharing will not breach client confidentiality regulations; consequently, information of a confidential nature will be provided in summary form only.

4. Coordination of physical, mental health, and SUD services: NCBH is partnering with two new Health Information Exchanges (HIEs) to improve coordination of physical, mental health, and SUD services: Sac Valley Med Share (SVMS) and CalMHSA Connex. The goal of participation in these HIEs will be to obtain close to real-time admission/discharge/transfer data related to hospitalizations and/or ED visits for NCBH clients, as well as the ability to view chart notes from the broader physical health system of care.

C. Inclusion of Cultural and Linguistic Competency in QI Program

On a regular basis, the QIC reviews collected information, data, and trends relevant to the National Standards for Culturally and Linguistically Appropriate Services in health and health Care (CLAS) to help address cultural competence and linguistic preferences.

The Quality Assurance Manager also serves as the MHP/DMC ODS Equity Services Manager (ESM), and chairs the Cultural Competency Committee (CCC) Meeting. As appropriate, QIC and CCC activities are shared or input taken which may be relevant to support cultural competent service provision or resource generation.

III. Data Collection – Sources and Analysis

A. Data Collection Sources and Types

Data collection sources and types include, but are not be limited to:

1. Utilization of services by type of service, age, gender, race, ethnicity, and primary language
2. Access Log (Initial contact log) (Children's, Adult, SUD)
3. Crisis Log
4. Test call logs
5. Notice of Adverse Benefit Determination Forms and Logs
6. Second Opinion requests and outcomes
7. Electronic Health Record Reports
8. Medication Monitoring forms and logs
9. Clinical Review QI Checklists (and plans of correction)
10. Peer Chart Review Checklists (and plans of correction)
11. Client Grievance/Appeal Logs; State Fair Hearing Logs
12. Change of Provider Forms and Logs
13. Special Reports from DHCS or studies in response to contract requirements
14. EQRO and Medi-Cal audit results
15. Annual DMC-ODS site review and audit results
16. Data from annual onsite monitoring /review of services, contracted services, and subcontracted services for programmatic and fiscal requirements.
17. Data from Power BI Dashboards, which are generated based on electronic health record reports

B. Data Analysis and Interventions

1. Data analysis is conducted in several ways. The SmartCare Electronic Health Record (EHR) system has several standard reports which managers and supervisors can utilize. NCBH has added significant analyst capacity to be able to build custom reports, run ad-hoc data analysis, and create new Power BI dashboards with data from the Electronic Health Record and other internal data sources such as SharePoint. NCBH uses an internal Administrative Analyst team to analyze client and system level data to track clients, services, outcomes and costs over time. NCBH leadership team members are also expected to monitor both dashboards and reports to identify corrective actions and/or workflow changes. Subsequent reviews are performed by the QIC. Additionally, the NCBH management team reviews various data elements monthly based on QI Plan goals, Cultural Competency Plan goals, as well as other performance indicators to measure system health.

2. New interventions receive input from individual staff, from committee meetings (including representatives of external agencies and consumers), and from management. Interventions have the approval of the Behavioral Health Director prior to implementation.

3. Effectiveness of interventions are evaluated by the QIC and the NCBH management team. Input from the QIC committee is documented in the minutes. These minutes document the activity, person responsible, and timeframe for completion. Each activity and the status for follow up are discussed at the next meeting.

IV. QI Activities, Goals, and Data

The Quality Improvement program for FY 25/26 includes the following goal areas, activities, data analyses, and projected objectives. Findings will be reported on the fiscal year to ensure completeness of data reported.

Ensuring Quality and Continuous Improvement: monitoring service delivery capacity, accessibility of services, and overall service delivery system performance
NCBH QI program will monitor, review, and evaluate the MHP and DMC ODS service delivery systems in multiple areas to assure service delivery capacity; accessibility; adequacy; compliance with new BHINs; and performance improvement, in accordance with statewide standards and local goals.

Goal Area 1: Utilization and Access, specifically the number of youth receiving DMC ODS services			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: NCBH will increase the number of youth ages 12 -17 served from 13 to 20.	NCBH participated in 30 training and outreach events for youth in 2025.	10 clients, ages 12 to 17, received DMC ODS services.	☐Met ☐Partially Met ☒Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: NCBH will increase the number of youth ages 12 -17 served from 10 to 15.	1. NCBH will facilitate at least one educational presentation to appropriate youth-serving organizations regarding youth SUD treatment options in Nevada County. 2. NCBH is working with the school system to identify a screening tool and pathway for referral for youth who are in need of services.	12/31/26

Goal Area 2: Accessibility of Services, specifically Timeliness (MHP and DMC-ODS)			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: NCBH will offer an appointment within 10 business days for all clients requesting mental health or substance use services 80% of the time. Additionally, NCBH will offer an appointment within 3 business days of a request for opioid treatment program services 80% of the time. This goal aligns with the DHCS Network Adequacy compliance standard and integrates previously separate goals.	Continued trainings were offered through both SUD and MH staff meetings. Timeliness data was reviewed during management meetings as well, to ensure that supervisors could review with individual teams.	In FY 24/25, Nevada County offered an assessment of appointment within 10 business days for all clients requesting MH and DMC-ODS services 91% of the time (772/849): • MH: 90% (608/676) • DMC-ODS: 95% (164/173) NCBH offered an appointment within 3 business days of a request for opioid treatment program services 100% of the time in FY 24/25 (110 of 110), and also 100% of the time in FY 23/24 (79 of 79).	☒ Met ☐ Partially Met ☐ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: A. NCBH will offer an appointment within 10 business days for all clients requesting mental health or substance use services 90% of the time. B. Additionally, NCBH will offer an appointment within 3 business days of a request for opioid treatment program services 80% of the time.	NCBH will continue to provide refresher trainings and new staff trainings on how to enter timeliness data based on the first offered appointment. NCBH will continue to track timeliness data at least quarterly in its QIC meetings, and will address deficiencies during the year if identified.	12/31/26

Goal Area 3 Accessibility of Services, specifically Timeliness of Urgent Requests (both MHP and DMC ODS)			
Evaluation FY24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY24/25**	**Status**
Goal for 2025: NCBH MHP and DMC-ODS will offer appointments within 48 hours to all clients who meet the criteria for urgent need 80% of the time. This goal aligns with the DHCS Network Adequacy compliance standard.	NCBH created a desktop guide for urgent definitions. Attended all team meetings and shared the desk top guide for urgent definitions to ensure staff understand the criteria for urgent.	NCBH MHP and DMC-ODS offered urgent appointments within 48 hours: 60% (3/5) urgent overall: • MH: 60% (3/5) • DMC ODS: 0 urgent requests	☐ Met ☐ Partially Met ☒ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: NCBH MHP and DMC-ODS will offer appointments within 48 hours to all clients who meet the criteria for urgent need 80% of the time. This goal aligns with the DHCS Network Adequacy compliance standard.	1. NCBH will continue to provide trainings on the definition of urgent to ensure accurate tracking. NCBH will continue to analyze current workflow processes to identify potential changes that would impact urgent requests for services and associated timeliness. 2. Behavioral Health Access Team screens request for service calls and screens the request to determine if urgent. Urgent requests will be offered services within 48 hours.	12/31/26

Goal Area 4 Utilization and Accessibility of Services, specifically Follow Up Appointments (both MHP and DMC ODS)			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: NCBH MHP and DMC ODS will offer follow-up appointments to qualifying beneficiaries within 10 business days of the initial appointment 80% of the time.	NCBH tracked follow-up appointment timeliness data quarterly at QIC meetings and with NCBH management and addressed deficiencies during the year as needed.	NCBH offered follow-up appointments within 10 business days of the initial appointment 89% (453/507): • MH: 91% (398/438) • DMC ODS: 80% (55/69)	☒ Met ☐ Partially Met ☐ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: NCBH will offer follow up appointments to qualifying beneficiaries within 10 business days of the initial appointment 90% of the time for MHP members and 85% for DMC-ODS members.	NCBH will track follow-up appointment timeliness data quarterly at QIC meetings and with NCBH management and will address deficiencies during the year if identified.	12/31/26

Goal Area 5 Utilization of Services, specifically Outpatient or Aftercare linkage for DMC ODS clients			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: Increase the percentage of individuals linked to outpatient treatment/ aftercare within 30 days of their discharge from residential treatment to 75%.	1. NCBH monitored linkage rates to outpatient after discharge from residential on quarterly basis. Residential providers submit data through a portal and NCBH discusses any trends quarterly. 2. NCBH added performance objectives to contracts for FY 25/26 for SUD residential providers to connect discharged patients to outpatient care within 30 days of discharge.	FY24/25 Data: 74% (167/225) of clients discharged from a residential DMC facility received a service from any DMC Outpatient Program within 30 days.	☐ Met ☒ Partially Met ☐ Not met
Workplan CY 2026			
Revised Objective (CY 2026)	Action Steps (Next year)		By Date:
Goal for 2026: This goal will be retired and the monitoring will be conducted by adding the outpatient aftercare linkage standards to the DMC-ODS provider subcontracts.	1. Add to FY upcoming contracts for SUD residential providers to connect discharged patients to outpatient care within 30 days of discharge. 2. Train DMC-ODS sub-contractors to outpatient aftercare linkage standards. 3. Monitor providers to ensure adherence to new contract provisions.		12/31/26

Goal Area 6: Utilization and Access of Services, specifically Responsiveness of 24/7 Line and Provision of Culturally Linguistically Appropriate Services			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: The NCBH 24-hour telephone service will provide information to the caller regarding the NCBH clinic location, phone and hours 90% of the time, including providing information to Spanish language callers.	Test call results were promptly tracked and findings were closely monitored. Targeted follow-up was conducted with appropriate staff if areas of concern were highlighted by the vendor completing the tests. Results were discussed periodically at QA Team Meetings and regulatory guidance, or training was provided to applicable staff, as appropriate.	FY 24/25 Data: The NCBH 24-hour toll free line provided the required information 98.4% of the time.	☒ Met ☐ Partially Met ☐ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: The NCBH 24-hour telephone service will provide information to the caller regarding the NCBH clinic location, phone and hours 95% of the time, including providing information to Spanish language callers.	1. Test call results will be promptly tracked and findings closely monitored. Targeted follow-up will be conducted with appropriate staff if areas of concern are highlighted by the vendor completing the tests. Results will be discussed periodically at QA Team Meetings and regulatory guidance or training provided to applicable staff, as appropriate. 2. Regular trainings will be held for 24/7 access line staff, and quarterly review of standards will be held with 24/7 team.	12/31/26

Goal Area 7 Utilization and Access of Services, specifically Access to After-Hours Care (MHP clients) and Strategies to Reduce Avoidable Hospitalizations			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: NCBH will increase the number of Mobile Crisis encounters to an average of 1.5 encounters per day.	Mobile Crisis Team has completed meet and greets, attended community events to advertise. There was a campaign over the holidays to advertise Mobile Crisis.	Average Daily Encounters: 1.6 Average Daily Medi-Cal Encounters: 1.4	☐ Met ☒ Partially Met ☐ Not met

Workplan CY 2026		
Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for CY 2026: NCBH will provide an average of at least 1.5 Mobile Crisis encounters per day.	1. NCBH will review average daily mobile crisis encounters monthly during contractor performance meeting. 2. NCBH will increase marketing and community outreach efforts as needed based on call volume and encounter data.	12/31/26

Goal Area 8 Monitoring Meaningful Clinical Issues, specifically Retention in DMC ODS treatment			
Evaluation FY24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY24/25**	**Status**
Goal for 2025: NCBH DMC ODS will sustain at least 61% of clients who maintained enrollment in an outpatient program for at least 90 days.	NCBH began monitoring DMC-ODS length of enrollment in outpatient programs. Aegis began reporting out percentage of clients enrolled in outpatient for at least 90 days in August 2025. All other SUD providers began reporting the following quarter. NCBH addressed necessary programmatic strategy changes as needed.	FY24/25 Data: 58.8% (679/1155) of clients maintained enrollment for at least 90 days.	☐ Met ☐ Partially Met ☒ Not met
Workplan CY 2026			
Revised Objective (CY 2026)	Action Steps (Next year)		By Date:
Goal for 2026: DMC ODS will increase percentage of clients who maintained enrollment in an outpatient program for at least 90 days to at least 61%.	NCBH will review DMC-ODS length of enrollment in outpatient programs and will send out provider-specific reports quarterly and will address necessary programmatic strategy changes as needed.		12/31/26

Goal Area 9: Monitoring Documentation Standards, specifically Timeliness of Entry of Service (both MHP and DMC ODS)			
Evaluation FY24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY24/25**	**Status**
Goal for 2025: NCBH staff will achieve timely entry of notes 80% of the time for services entered (timely defined as date of entry of note within 3 days of the date of service).	Management team review of this goal. During chart audits, feedback is provided to supervisors if there are charts/ clinicians who is not submitting timely notes.	FY24/25 Data: 72% of progress notes were completed within 3 days of the date of service	☐ Met ☐ Partially Met ☒ Not met
Workplan CY 2026			
Revised Objective (CY 2026)	Action Steps (Next year)		By Date:
Goal for 2026: NCBH staff will achieve timely entry of notes 80% of the time for services entered (timely defined as date of entry of note within 3 days of the date of service).	Management team review of this goal. During chart audits, feedback is provided to supervisors if there are charts/clinicians who is not submitting timely notes. Targeted training for clinicians who are not meeting timeliness requirements.		12/31/26

Goal Area 10: Monitoring Performance Improvement and PIPS, specifically implementation, follow through, resolution, and confidence ratings (Both MHP and DMC ODS)			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: NCBH will submit the PIP Validation forms required by DHCS by July 2026.	Validation forms were submitted in a timely manner, core team meets for PIP implementation and review twice per month. Meetings will continue at this cadence as interventions are built and implemented for each PIP.	Health Services Advisory Group (HSAG) approved the validation forms and PIP topics.	☒ Met ☐ Partially Met ☐ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
New Goal 2026: NCBH will build interventions for each PIP topic based on data gathered during targeted stakeholder meetings that identified gaps and barriers to service delivery. PIP topics have been identified as increasing the number of Peer Services received by county Medi-Cal members as well as increasing the follow up rate for members who are seen at the Emergency Department with a primary diagnosis of Substance Use Disorder.	Interventions will be implemented with progress toward goals monitored and tracked. Additionally, the QA Team will ensure timely submissions of all deliverables to Health Services Advisory Group (HSAG) related to intervention creation and implementation stages.	12/31/26

Goal Area 11 Supporting and Increasing Stakeholder Involvement, specifically Client and Family Engagement (both MHP and DMC ODS)			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: Increase consumer involvement in QI-related activities and feedback.	A consumer began attending QIC regularly in the 4th quarter of the year. NCBH facilitated one Consumer town hall. NCBH completed report out of select QIC information quarterly to the Consumer Advisory Council.	A consumer began attending QIC regularly in the 4th quarter of the year. NCBH facilitated one Consumer town hall. NCBH completed report out of select QIC information quarterly to the Consumer Advisory Council.	☒ Met ☐ Partially Met ☐ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: Increase consumer involvement in QI-related activities and feedback.	1. Provide any needed support and encouragement to QIC consumer member to continue to attend QIC meetings throughout 2026. 2. Facilitate at least one Consumer town hall to solicit system feedback and suggestions for improvement. 3. NCBH will continue to report out select QIC information quarterly to the Consumer Advisory Council.	12/31/26

Goal Area 12: Monitoring Service Delivery Quality and Utilization, specifically through Peer Reviews (both MHP and DMC ODS)			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: QA/QI Department will re-implement peer driven chart monitoring program. Identified NCBH staff will review a minimum of 6 charts per month for adult SMHS, 6 charts for children services, and 6 charts for DMC-ODS to monitor quality of services and compliance with Medi-Cal documentation with a goal of no more than 5% disallowances for services from these chart audits.	Peer driven chart review process was fully implemented. New audit tool was rolled out. QA Manager trained all teams on use of new tool.	NCBH staff reviewed a minimum of 6 charts per month for adult SMHS, 6 charts for children services, and 6 charts for DMC-ODS for compliance with Medi-Cal documentation with no disallowances for services from these chart audits.	☒ Met ☐ Partially Met ☐ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal for 2026: QA/QI Department will continue to implement peer driven chart monitoring program. Identified NCBH staff will review a minimum of 6 charts per month for adult SMHS, 6 charts for children services, and 6 charts for DMC-ODS to monitor quality of services and compliance with Medi-Cal documentation with a goal of no more than 5% disallowances for services from these chart audits.	Use chart tracking tool to ensure that chart audits are being completed to standard/regulatory guidance.	12/31/26

Goal Area 13 : Monitoring Grievance and Complaint Processes, specifically Required Response Time (both MHP and DMC ODS)			
Evaluation FY 24/25			
Last year's Objective/Goal	**What was done**	**Findings from FY 24/25**	**Status**
Goal for 2025: NCBH will respond to all MH and SUD grievances in writing to the beneficiary within 5 days of receipt of the grievance. Goal will be retained.	The goal of responding to grievances in writing within 5 days was not always met. Barriers were members not having addresses to receive communications, PRA not available.	The goal of responding to grievances in writing within 5 days was not always met. Of the 26 grievances that were filed in FY 24/25, 18 required a written acknowledgement letter. 14 of the 18 (78%) were provided with the letter within 5 days. Barriers were members not having addresses to receive communications, PRA not available.	☐ Met ☐ Partially Met ☒ Not met

Workplan CY 2026		
Revised Objective (CY 2026)	Action Steps (Next year)	By Date:
Goal 2026: NCBH will provide an acknowledgement letter for 90% of all MH and SUD grievances in writing to the beneficiary within 5 days of receipt of the grievance. Goal will be retained. The eventual goal will be to provide acknowledgement letters for all grievances but will establish an achievable goal (90%) for this year during the transition to a new PRA.	1. NCBH has a new Patients Rights Advocate (PRA) starting on 2/1/2026. The onboarding process for the new PRA will emphasize the need to provide an acknowledgement letter for all grievances in writing to the beneficiary within 5 days of receipt of the grievance. 2. Provide training to staff, closer monitoring of the logs, and will implement a new grievance system for members to submit grievances electronically through the website. 3. Will implement a system to notify QA team members to provide back up when the PRA is out of the office.	12/31/26

Delegated Activities Statement

At the present time, NCBH does not delegate any review activities. Should delegation take place in the future, this Plan will be amended accordingly.

FY 24/25 Nevada County Behavioral Health Position Control

Total Filled	Total Positions	Vacancy Rate
57.25	72.75	21%

Class Title	Clinical	Filled	Positions	Vacancy Rate
Behavioral Health Quality Assurance Manager	N	0	1.00	100%
Behavioral Health Nurse I/II	Y	0.9	3.00	70%
Behavioral Health Medical Director	Y	0.6	1.00	40%
Administrative Analyst I/II	N	2	3.00	33%
Behavioral Health Worker I/II/III	Y	11	16.00	31%
Behavioral Health Therapist I/II/Licensed	Y	15.75	19.75	20%
Program Manager	N	4	5.00	20%
Behavioral Health Clinic Supervisor I/II	Y	5	6.00	17%
Administrative Assistant I/II	N	1	1.00	0%
Director of Behavioral Health	N	1	1.00	0%
Behavioral Health Clinical Administrator	N	1	1.00	0%
Health Technician I/II	N	9	9.00	0%
Quality Assurance BH Ther—Lic	N	1	1.00	0%
Senior Administrative Analyst	N	1	1.00	0%
Senior Health Technician	N	2	2.00	0%
Supervising Health Technician	N	1	1.00	0%
Staff Psychiatrist	Y	1	1.00	0%

DHCS | County Portal

Behavioral Health Director Certification

Certification

1. I hereby certify that Nevada County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - ✔ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ✔ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - ✔ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ✔ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ✔ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - ✔ The IP was submitted to the local behavioral health board

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

   - ○ Yes
   - ◉ No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

County Behavioral Health Agency Director contact information

3. County Name

Nevada County

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

4a. Submission type

- (•) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Cari Yardley

6. County Behavioral Health Agency Director phone number

(530) 470-2559

7. County Behavioral Health Agency Director email

cari.yardley@nevadacountyca.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name
    Cari Yardley
13. Title
    Acting Behavioral Health Director
14. Date
    3/25/26
15. Signature

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name
17. Title
18. Date
19. Signature

County Administrator or Designee Certification

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

Nevada County

Signature

3. Print name

4. Date
   Nevada County

5. Signature

Contact information

6. County Name
   Cari Yardley

7. Certification for

   - Three-Year Integrated Plan
   - Annual Update
   - Intermittent Update

7a. Submission type

   - Draft

8. County Chief Administration Officer Name
   (530) 470-2559

9. County Chief Administration Officer Phone number
   cari.yardley@nevadacountyca.gov

10. County Chief Administration Officer Email

Board of Supervisors Certification

Certification

1. Nevada County Board of Supervisors certifies the following:

   ✔ Nevada Coun 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)

Nevada County

Signature

3. Printed name

   Cari Yardley

4. Title

   (530) 470-2559

5. Date

cari.yardley@nevadacountyca.gov

6. Signature