2026 - 2029 Integrated Plan

Tri-City

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
Joint Powers

Entity Name
Tri-City Mental Health Authority

Behavioral Health Agency Name
Tri-City Mental Health Authority

Behavioral Health Agency Mailing Address
1717 N. Indian Hill Blvd. Ste B Claremont, Ca 91711

Primary Mental Health Contact

Name
Elizabeth (Liz) Renteria

Email
erenteria@tricitymha.ca.gov

Phone
9097667324

Secondary Mental Health Contact

Name
Deborah Johnson

Email
djohnson@tricitymha.ca.gov

Phone
9097667307

Primary Substance Use Disorder Contact

Name
Elizabeth (Liz) Renteria

Email
erenteria@tricitymha.ca.gov

Phone
9097667324

Secondary Substance Use Disorder Contact

Name
Markie Sterner

Email
msterner@tricitymha.ca.gov

Phone
9097667295

Primary Housing Interventions Contact

Name
Mary Monzon

Email
mmonzon@tricitymha.ca.gov

Phone
9093264624

Compliance Officer for Specialty Mental Health Services (SMHS)

Name
Natalie Majors

Email
nmajors@tricitymha.ca.gov

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

Name
Natalie Majors

Email
nmajors@tricitymha.ca.gov

Behavioral Health Services Act (BHSA) Coordinator

Name	Email address
Sara Rodriguez	srodriguez@tricitymha.ca.gov
Dana Barford	dbarford@tricitymha.ca.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

Name	Email address
Elizabeth (Liz) Renteria	erenteria@tricitymha.ca.gov

Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email address
Natalie Majors	nmajors@tricitymha.ca.gov
Tatiana Van Beeck	tvanbeeck@tricitymha.ca.gov

Medical Director

Name	Email address
Dr. Seeyam Teimoori MD	steimoori@tricitymha.ca.gov

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)	793
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	000
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	000
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	000

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	24
Were chronically homeless or experiencing homelessness or at risk of homelessness	23
Were in the juvenile justice system	000
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	793
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	000

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	67

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	136
Received Medi-Cal SMHS	2028
Received DMC or DMC-ODS services	000
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	000
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	600

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	600
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	129
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	000
Were in the justice system (on parole or probation and not currently incarcerated)	124
Were incarcerated (including state prison and jail)	143
Reentered the community from state prison or county jail	143
Received acute psychiatric services	195

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

Admitted or detained for 72-hour evaluation and treatment rate

000

Admitted for 14-day and 30-day periods of intensive treatment
000

Admitted for 180-day post certification intensive treatment
000

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
000

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
000

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
The data for this section came from client data from our Electronic Health Record for children and adults using service, demographic, and financial data. Information regarding justice involvement came from the Partnership Assessment Form for FSP participants. This information is from Fiscal Year July 1, 2023, to June 30, 2024.

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.
Accordingly, Tri-City's CARE Court integration will be implemented in coordination with and through LACDMH's established CARE Court infrastructure, consistent with statewide CARE Act requirements and County-designated processes. This approach ensures system alignment, avoids fragmentation, and maintains compliance with the County's role as the legally responsible entity for CARE Court intake, eligibility determination, court coordination, and treatment plan oversight.

Service components, priority access, and specialized coordination: CARE Court participants will be supported through TCMHA's Direct Link Outreach Program, Assertive Field-Based Teams, Full-Service Partnership (FSP) programs, and Access to Care teams. These teams will receive specialized training to support CARE Court individuals, including engagement, care planning, and coordination requirements. CARE Court clients will be prioritized for rapid linkage to clinically indicated services across the continuum (including housing interventions when appropriate) through coordinated planning, repeated engagement attempts, and ongoing monitoring via established care coordination processes. Additionally, staff will liaison with LACDMH and LA County court systems to ensure smooth coordination.

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

Accordingly, Tri-City's CARE Court integration will be implemented in coordination with and through LACDMH's established CARE Court infrastructure, consistent with statewide CARE Act requirements and County-designated processes. This approach ensures system alignment, avoids fragmentation, and maintains compliance with the County's role as the legally responsible entity for CARE Court intake, eligibility determination, court coordination, and treatment plan oversight.

Integration of CARE referral pathways into the county behavioral health system: CARE Court referral pathways will be integrated into existing TCMHA access and referral systems to ensure continuity and alignment with established workflows. While integrated into current systems, CARE Court referrals will include a fast-track process, reviewed and coordinated as part of the weekly care coordination meeting to support timely assignment, expedited scheduling, and cross-team problem-solving for engagement, clinical care, and housing-related coordination as needed.

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.

Accordingly, Tri-City's CARE Court integration will be implemented in coordination with and through LACDMH's established CARE Court infrastructure, consistent with statewide CARE Act requirements and County-designated processes. This approach ensures system alignment, avoids fragmentation, and maintains compliance with the County's role as the legally responsible entity for CARE Court intake, eligibility determination, court coordination, and treatment plan oversight.

Through ongoing screening, triage, and clinical assessment conducted by Access to Care, Direct Link Outreach, and Assertive Field-Based Teams, individuals will be evaluated for CARE Court appropriateness. When a formal CARE Court petition is not required or clinically appropriate, individuals will be redirected to alternative pathways within the County behavioral health system.

These alternative pathways may include Full-Service Partnerships, Alternative Outpatient Treatment (AOT), or other clinically indicated services based on level-of-care determinations, safety considerations,

functional need, and client preference, consistent with the County's service array and guidance. TCMHA will utilize the Service Array Guide and established placement tools to ensure individuals are connected to the most appropriate intensity and type of support.

For individuals redirected from CARE Court consideration, successful linkage will be confirmed and documented through warm handoffs, verification of initial engagement or appointment attendance, and ongoing care coordination tracking within existing systems. Documentation practices will align with LACDMH requirements to support continuity, accountability, and quality oversight.

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

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

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

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

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?
Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

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

Opioid Settlement Funds (OSF)

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

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

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:

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

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?

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?

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

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

Other Programs and Services

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

Program or service

Care Transitions

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

Yes

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

No

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
Race or Ethnicity
Sex

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
Below

For children/youth
Below

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

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

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis

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

Tri-City Mental Health Authority (TCMHA) reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall adult NSMHS rate for LA County (7.7%) falls below the State mean (10.6%). Within LA County, disparities exist for different population groups. Regarding age, the penetration rates for age groups 57-68 (8.7%) and 69+ (6.6%) are below the county rate (8.9%). Regarding sex, the rate for males (5.8%) is below the county rate (8.9%). Regarding race, the rates for Hispanic (8.3%) and Asian/Pacific Islander (5.5%) are below the county rate (8.9%). Lastly, regarding language, the rates for Farsi (8.7%), Arabic (6.8%), Spanish (6.3%), Armenian (5.9%), Other Non-English (5.5%), Mandarin (4.3%), Korean (3.7%), Vietnamese (3.1%), Tagalog (3%), Cantonese (3%), Thai (2.2%), and Other Chinese Language (2.1%) are below the county rate (8.9%).

Access to Care – Children & Youth NSMHS

TCMHA reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall children & youth NSMHS rate for LA County (12.6%) falls below the State mean (15.5%). Within LA County, disparities exist for different population groups (FY 2022). Regarding age, the penetration rates for age groups 6-11 (8.2%) and 18-20 (8.3%) are below the county rate (11.8%).

Regarding sex, the rate for females (11.5%) is below the county rate (11.8%). Regarding race, the rates for Hispanic (11.5%) and Black/African American (10.3%) groups are below the county rate (11.8%). Lastly, regarding language, the rates for Other Chinese Language (11.5%), Spanish (11.3%), Other Non-English (10.3%), Arabic (10%), Tagalog (8.6%), Russian (7%), and Armenian (4.3%) are below the county rate (11.8%).

Access to Care – Adult SMHS

TCMHA reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall adult SMHS rate for LA County (3.8%) exceeds the State mean (3.4%). Within LA County, disparities exist for different population groups (FY 2022). Regarding age, the penetration rate for age group 65+ (1.9%) is below the county rate (4.3%). Regarding sex, the rate for females (4.0%) is below the county rate (4.3%). Regarding race, the rates for Hispanics (3.1%), and Asian/Pacific Islanders (2.1%) are below the county rate (4.3%).

Access to Care – Children & Youth SMHS

TCMHA reviewed the LA County FY 2023 (overall rates) and FY 2022 (demographic group rates) data from the CalMHSA Dashboard. The overall children & youth SMHS rate for LA County (5.5%) exceeds the State mean (4.2%). Within LA County, disparities exist for different population groups (FY 2022). Regarding age, the penetration rates for age groups 0-2 (2.1%), 3-5 (3.2%), and 18-20 (5.5%) are below the county rate (5.9%). Regarding sex, the rate for males (5.7%) is below the county rate (5.9%). Regarding race, the rates for White/Caucasian (5.7%), Asian/Pacific Islander (2.3%), and Other Race (3.5%) are below the county rate (5.9%).

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

To address disparities among Medi-Cal eligible adults aged 65+, who access Specialty Mental Health

services (SMHS) at a lower rate (1.9%) compared to the State penetration rate 4.3%, TCMHA plans to address barriers to accessing treatment. Plans include targeted outreach in local spaces where older adults gather, such as community centers, senior centers and assisted living communities; stigma reduction strategies; providing resources to address transportation challenges; and offering different methods of service delivery such as in-home services and telehealth options. Providing support and information about telehealth services may assist older adults in accessing different forms of service delivery that are available to them. Another approach is to collaborate with healthcare providers to provide whole person care as many older adults have co-morbid health conditions. One goal would be to start addressing barriers to treatment at the time-of-service request and continue throughout treatment.
Disparities exist among Hispanic (3.1%) and Asian (2.1%) Medi-Cal eligible adults who access Specialty Mental Health Services when compared to the state penetration rate of 4.3%. Disparities exist among Asian (2.3%) and other race (3.5%) Medi-Cal eligible children who access Specialty Mental Health Services when compared to the state penetration rate of 5.9%. Plans to address these disparities consist of targeted outreach in communities of Hispanic and Asian adults and children by collaborating with local schools and community organizations within TCMHA's service area. Continued focus will be on ensuring a diverse community of providers who are culturally competent and can offer bilingual services. TCMHA will continue to have language interpreter services available to meet language needs. Immigration and related legal concerns may prevent Hispanic and Asian adults, children, and families from accessing SMHS. Discussing confidentiality and reinforcing that TCMHA is a ‘safe space’ can assist in building trust amongst those who may be fearful. Having resources available that address immigration-related barriers for impacted communities will also be helpful.
The rates for Medi-Cal eligible children aged 0-2 (2.1%) and children aged 3-5 (3.2%) accessing Specialty Mental Health services are below the State penetration rate of 5.9%. Marketing and outreach in the cities of Pomona, Claremont, and La Verne are key to ensuring that the community is aware of services offered to young children. Recognition of mental health symptoms in young children is usually low, and providing psychoeducation to school and community members will assist in helping caregivers, providers, and families access mental health services for young children. Creating a pathway for referrals from warm handoffs between child welfare institutions such as the Department of Child and Family Services (DCFS) and schools to TCMHA mental health services will assist with addressing access disparities. Additional training for providers on appropriate evidence-based practices (EBPs), birth to 5 competencies, and completing ICARES assessments for youth 0-5 years old will be important in creating access to care for the 0-5 population.

The overall rate of Medi-Cal eligible adults accessing Non-Specialty Mental Health (NSMHS) services in Los Angeles County (7.7%) falls below the state mean (10.6%). The overall rate of Medi-Cal eligible adults accessing Specialty Mental Health Services in Los Angeles County (3.8%) is higher than the state rate (3.4%). Children access NSMHS at a lower rate in Los Angeles County (12.6%) when compared to the State rate (15.5%); children access SMHS at a higher rate in Los Angeles County (5.5%) when compared to the state rate of 4.2%. One goal is to utilize screening tools at the time-of-service request and at intake to assist in assessing and determining the appropriate level of care. This aim includes training staff to be competent at

utilizing tools to appropriately screen and assess individuals for the proper level of care. Additionally, establishing memoranda of understanding (MOUs) with local Managed Care Plans (MCPs) and other providers to facilitate warm-handoffs and proper transitions of care is important in supporting this goal.

File Upload

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

BHSA Behavioral Health Services and Supports (BHSS)
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)

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
Gender
Race or Ethnicity

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?
Race or Ethnicity
Other

Please describe other
Other: grade level (varies), English learner (8.1%), students with disabilities (4.9%) and migrant status (8.4%) are all above the county rate (4.5%).

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
Gender
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
Homelessness – PIT Rate of People Experiencing Homelessness

TCMHA reviewed the LA County FY 2024 rates from the CalMHSA Dashboard. The Point-in-Time (PIT) rate for LA County (78) is higher than the state mean (48). Within LA County, population groups experience disparities (FY 2024). Regarding age, the rates for the age group 35-44 (110) and 45+ (80) are above the county rate (78). Regarding gender, the rate for males (94) is above the county rate (78). Regarding race, the rates for American Indian/Alaska Native (578), Black/African American (278), Native Hawaiian (134), and multiple races (81) are above the county rate (78).

Homelessness – Rate of K-12 Students Experiencing Homelessness

TCMHA reviewed the LA County FY 2023-24 rates from the CalMHSA Dashboard. The rate for LA County (4.5%) is below the State mean (5.3%). Within LA County, different groups experience disparities (FY 2023-24). Regarding grade level, the rates for kindergarten (4.8%), grade 1 (4.6%), grade 2 (4.6%), grade 3 (4.7%), grade 4 (4.8%), grade 5 (4.7%), and grade 9 (4.6%) are all above the county rate (4.5%). Regarding race, the rates for American Indian/Alaska Native (7.9%), African American (7.4%), Pacific Islander (6.2%), and Hispanic/Latino (5.3%) are all above the county rate (4.5%).

Homelessness – Rate of People who Accessed Homelessness Services – Supplemental Goal

TCMHA reviewed FY 2024 rates from the CalMHSA Dashboard. The rate for LA County (119) exceeds the State mean (91). Within LA County, different groups experience disparities (FY 2024). Regarding age, rates for under 18 (87), 18-24 (87), and 65+ (42) are below the county rate (119). Regarding gender, the rate for females (85) is below the county rate (119). Regarding race, the rates for Hispanics (85), White/Caucasian (74), and Asian/Pacific Islander (9) are below the county rate (119).

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)

TCMHA plans to strengthen and implement several programs, services, and partnerships to reduce homelessness among individuals experiencing severe mental illness (SMI), severe substance use disorders (SUD), and co-occurring conditions. A key initiative will be the development of a Direct Link Outreach Team, staffed through Full-Service Partnership (FSP) programs including FSP- Intensive Case Management FSP Assertive Community Treatment (ACT), Forensic Community Treatment (FACT) Housing Navigators, Mobile Crisis Care and street psychiatry and inclusive of other treatment team members. This team will provide proactive, field-based engagement, housing support services, offer immediate access to coordinated mental health and substance use services, and deliver integrated care for individuals with co-occurring disorders in unsheltered and high-need settings.

TCMHA also plans to work with community partners to establish a Homelessness Coalition that will formalize collaboration with cities, local law enforcement, housing providers, hospitals, and other community agencies. This coalition will focus on coordinated outreach, diversion from incarceration and emergency departments, shared data strategies, and streamlined access to housing and treatment resources. These partnerships are intended to address service gaps that contribute to outcomes below the statewide average, particularly in engagement, continuity of care, and housing stability for individuals with complex behavioral health needs.

Program development has been informed by local data that indicate approximately 46% of adult FSP clients and 22% of transition-age youth clients served by TCMHA have co-occurring mental health and substance use disorders. These data highlights a critical need for integrated, multidisciplinary approaches that address both conditions simultaneously. By expanding field-based outreach, strengthening cross-system coordination, and prioritizing interventions for individuals with co-occurring disorders—who experience higher rates of homelessness and poorer outcomes—TCMHA aims to improve engagement, reduce system fragmentation, and achieve measurable reductions in homelessness within this population, consistent with local needs and statewide performance benchmarks.

Tri-City Mental Health Authority provides coordinated, community-based support to individuals and families experiencing homelessness in the cities of Claremont, Pomona, and La Verne. Through its Direct Link Outreach model, Tri-City delivers field-based services across Full Service Partnership (FSP), Forensic

Assertive Community Treatment (FACT), Assertive Community Treatment (ACT), Intensive Case Management (ICM), Individual Placement and Support (IPS), and specialized Housing teams.

At the core of this work is a dedicated Housing Team that guides individuals through the full housing continuum—from initial street outreach and engagement to benefits enrollment, housing navigation, placement, and long-term stabilization. The team addresses key barriers to housing stability, including income limitations, documentation challenges, and unmet behavioral health needs, ensuring clients are positioned for sustained success in permanent housing.

Through strong community partnerships, the Housing Team supports street outreach efforts and facilitates access to emergency shelter, interim housing, permanent supportive housing (PSH), and other long-term housing options. Partnerships include collaboration with local shelter providers such as Hope for Home, as well as interim and permanent housing programs throughout the region.

In partnership with the Cities of Claremont, Pomona, and La Verne, Tri-City advances innovative housing solutions that expand local capacity and create dedicated housing opportunities for vulnerable residents. Current initiatives include collaboration on the St. Ambrose housing project in Claremont, the Tiny Homes initiative with the City of Pomona, and development of the Baseline Road housing project designed to serve eligible seniors. Collectively, these efforts strengthen the regional continuum of care and expand access to safe, stable, and permanent housing.

Dedicated Housing Team providing navigation, placement, and stabilization.

Field based outreach through FSP FACT, ACT,ICM, IPS , and Housing teams.

Street outreach

Emergency shelter (e.g., Hope for Home)

Interim housing

Permanent Supportive Housing (PSH)

TCMHA provides comprehensive, coordinated services to individuals and families experiencing homelessness across Claremont, Pomona, and La Verne. Central to this work is our dedicated Housing Team, which assists unhoused clients in navigating housing resources, securing permanent housing

placements, and maintaining housing stability once housed. The team works closely with clients to address barriers to housing, connect them to benefits, and ensure access to ongoing supports. City Mental Health Services provides comprehensive, coordinated services to individuals

TCMHA collaborates extensively with the three cities on a range of innovative housing initiatives designed to expand local housing capacity. These efforts include partnering on new housing developments and securing dedicated beds or units for eligible clients, such as the St. Ambrose housing project in Claremont and the Tiny Homes initiative in collaboration with the City of Pomona. In addition, TCMHA is financing a Baseline Road housing project specifically designed to serve eligible seniors, further strengthening the continuum of housing options for vulnerable populations. City collaborates extensively with the three cities on a range of innovative housing initiatives designed to expand local housing capacity. These efforts include partnering on new housing developments and securing dedicated beds or units for eligible clients, such as the St. Ambrose housing project in Claremont and the Tiny Homes initiative in collaboration with the City of Pomona. In addition, TriCity is financing a Baseline Road housing project specifically designed to serve eligible seniors, further strengthening the continuum of housing options for vulnerable populations.

Beyond new developments, TCMHA continues to operate two housing apartment projects, providing stable, supportive housing environments for residents. Across all housing programs, TCMHA delivers comprehensive community services and supports simultaneously, including mental health treatment, case management, and connections to physical health care, substance use services, and social supports. This integrated approach ensures that individuals not only obtain housing, but also receive the ongoing services necessary to support recovery, wellness, and long-term housing stability. TCMHA continues to operate two housing apartment projects, providing stable, supportive housing environments for residents. Across all housing programs, TCMHA delivers comprehensive community services and supports simultaneously, including mental health treatment, case management, and connections to physical health care, substance use services, and social supports. This integrated approach ensures that individuals not only obtain housing but also receive the ongoing services necessary to support recovery, wellness, and long-term housing stability. City continues to operate two housing apartment projects, providing stable, supportive housing environments for residents. Across all housing programs, TriCity delivers comprehensive community services and supports simultaneously, including mental health treatment, case management, and connections to physical health care, substance use services, and social supports. This integrated approach ensures that individuals not only obtain housing, but also receive the ongoing services necessary to support recovery, wellness, and long-term housing stability.

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

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
Above

For children/youth
Not Applicable

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

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
Above

Permanent Conservatorships
Above

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
Above

For children/youth
Above

Crisis Residential Treatment Services

For adults/older adults
Above

For children/youth
Below

Crisis Stabilization

For adults/older adults
Below

For children/youth
Below

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

Institutionalization – Average Number of Inpatient Administrative Days (Adults)

TCMHA reviewed FY 2023 (overall average) and FY 2022 (demographic group average) data from the CalMHSA Dashboard. The overall average for LA County (35.3) is above the State mean (25.6). Within LA County, different population groups experience disparities (FY 2022). Regarding age, the average rate for age group 57-68 (53) is above the county rate (35.3).

Institutionalization – Average number of minutes of crisis intervention services utilized by individual – Supplemental Goal - ADULTS

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (351) is above the State average (240). Within LA County, different population groups experience disparities (FY 2023). Regarding race, the average rates for for Asian American or Pacific Islander (358) and Black (353) populations are above the county rate (351). Regarding language, the average rates for Korean (540) and Mandarin (459) are above the county rate (351).

Institutionalization – Average number of minutes of crisis intervention services utilized by individual – Supplemental Goal - YOUTH

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (330) is above the State average (267). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the average rates for age groups 12-17 (417), 18-20 (343), and 6-11 (335)) are above the county rate (330). Regarding race, the average rates for Black (460), Other (370), White (366), Hispanic (352), and Asian or Pacific Islander (339) populations are above the county rate (330). Regarding sex, the average rates for both females (378) and males (361) are above the county rate (330). Regarding language, the average rates for Vietnamese (525), Mandarin (403), English (383), Cantonese (357), and Spanish (340) are above the county rate (330).

Institutionalization – Average number of minutes of crisis stabilization by individual – Supplemental Goal - ADULTS

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (18) is below the State average (24). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the average rates for age groups 45-56 (18.53) and 33-44 (18.4) are above the county average (18). Regarding race, the average rates for Black (20), White (19), Other (18.29), and Alaskan Native or American Indian (18.15) populations are above the county average (18). Regarding sex, the average rate for males (19) is above the county average (18). Regarding language, English (18.23) is above the county average rate (18).

Institutionalization – Average number of minutes of crisis stabilization by individual – Supplemental Goal - YOUTH

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (14) is below the State average (19). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the average rate for age group 12-17 (15) is above the county average (14). Regarding race, the average rates for Black (18), White (16), and Other (15) populations are above the county average (14). Regarding sex, the average rates for both females (14.97) and males (14.42) are above the county average (14). Regarding language, English (15) is above the county average rate (14).

Institutionalization – Average number of minutes of crisis residential treatment services by individual – Supplemental Goal – ADULTS

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (29) exceeds the State average (23). Within LA County, no adult population groups are experiencing disparities in crisis residential treatment

services for FY 2023.

Institutionalization – Average number of minutes of crisis residential treatment services by individual – Supplemental Goal – YOUTH

TCMHA reviewed FY 2023 (average minutes) and FY 2023 (demographic group average minutes) data from the CalMHSA Dashboard. The average number of minutes for LA County (20) is below the State average (22). Within LA County, different population groups experience disparities (FY 2023). Regarding age, youth 18-20 (21.32) is above the country average (20). Regarding sex, the average rate for female (26) is above the county average (20). Regarding language, English (23) is above the county average (20).

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
We are a JPA/City and do not have access to this local data specific to our three cities.

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)

Based on the institutionalization data, we are above the statewide data provided by CALMHSA across many domains; including inpatient days, temporary and permanent conservatorships, as well as crisis interventions. This may be due to lack of knowledge of resources and services provided by Tri-City. Therefore, TCMHA plans to reduce institutionalization rate through various measures that include effective outreach, engagement, crisis response, and treatment. Programming and services that incorporate peer support, first episode psychosis, psychoeducation, Individual Placement and Support (IPS) Supported

Employment, and community partnerships can reduce institutionalization.

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) are considered the highest level of care for individuals with severe mental illness who are at risk of hospitalization. Individuals participating in ACT or FACT services receive regular weekly visits that can be increased during times of crisis/stress to prevent escalation. ACT and FACT teams are composed of multi-disciplinary positions (psychiatrist, registered nurse, clinician, peer, behavioral health specialists) that provide a recovery and whole -person care approach within a team setting. ACT teams are closely involved in hospital admissions and hospital discharge for individuals to ensure continuity of care, coordinate services, and provide support and advocacy.

Peer staff are vital to helping instill hope and promoting recovery to the severe mental illness (SMI) population who often experience multiple hospitalizations or long-term hospitalization. Clients can benefit from incorporating peers in ACT/FACT and TCMHA's overall system of care. Peers are embedded in TCMHA's Mobile Crisis Care team and communicate hope in times of great distress, connect individuals to support networks, and model the fact that recovery is possible. Peers support individuals in accessing and participating services.

TCMHA's Mobile Crisis Care team is available 24/7 and provides phone and field response as needed for any behavioral health crisis. Trained to provide trauma-informed and culturally responsive crisis response (including Language Line interpretation/translation services, as necessary), the Mobile Crisis Care team responds in pairs on their own, with designated TCMHA treatment team members, or in co-response with law enforcement when needed. Mobile Crisis Care helps with de-escalation of crisis, connecting individuals to their support network or treatment teams, and follow-up connecting to behavioral health services and needed resources (i.e. food banks, health care, housing resources, etc.) as alternatives to hospitalization when appropriate. The team also provides outreach and debriefs to the community after critical incidents to provide additional support, psychoeducation on mental health, and access to behavioral health services.

TCMHA's Coordinated Specialty Care First Episode Psychosis program offers treatment, outreach, and workshops to inform the community about the early warning signs of psychosis, corresponding treatment, and how to access services. FEP provides services for individuals ages 12-25 who present with criteria for clinically high risk or experiencing a first psychotic episode. Services can be provided in the community or office to help remove barriers to services. Early identification and treatment of psychosis can lead to better recovery, long term outcomes, and overall reduction of psychiatric hospitalizations.

Both the CSC FEP and ACT teams provide psychoeducation to the individual and supportive people in their lives to assist with safety planning, reducing stressors, and helping with hospitalization when appropriate. Families/Supportive individuals participate in psychoeducation workshops and multi-family groups to help develop knowledge of psychosis, awareness of triggers and stressors that lead to increase in symptoms, and provide effective support when symptoms escalate. Individuals and families are provided with information regarding the difference between voluntary and involuntary hospitalization, the individual's rights, and overall process of a 5150/5585. Treatment teams and Mobile Crisis teams support individuals and families with the steps of voluntary hospitalization by connecting individuals to local psychiatric hospitals and transportation when possible.

TCMHA will also implement evidence-based Individual Placement and Support (IPS) Supported Employment to all adults receiving behavioral health services. Satisfying employment is a key factor in recovery for many individuals with mental illness. IPS services will be available for as long as individuals need them and follow an individualized approach. Individuals with mental illness who have employment can benefit from increased self-esteem, better control of psychiatric symptoms, and reduction of psychiatric hospitalizations and justice involvement.

TCMHA will continue to strengthen partnerships with local community agencies including schools, local law enforcement, and hospitals to help identify individuals who are underserved or untreated in the community and intervene before hospitalization. Collaborative meetings will be held to discuss individuals who have failed to connect to services and create a pathway to care for them. The local emergency room (ER) will identify and refer individuals who present a primary need for behavioral health services to increase access to services for high-risk individuals.

File Upload

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

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

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
Below

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

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?
Below

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

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered

to county-funded programs are not included in this count.

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

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

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
Justice Involvement – Arrest Rate per 100,000 People by Count – Adult

TCMHA reviewed FY 2023 (rates) and FY 2024 (demographic group rates) from the CalMHSA Dashboard. The rate for LA County (2,066) is lower than the State rate (2,440). Within LA County, population groups experience disparities (FY 2024). Regarding age, the rates for age groups 20-29 (3,118) and 30-39 (3,577) are above the county rate (1,987). Regarding sex, the rate for males (3,189) is above the county rate (1,987). Regarding race, the rate for total population (including adults/juvenile) for black people (4,526) is above the county rate (1,644).

Justice Involvement – Arrest Rate per 100,000 People by Count – Juvenile

TCMHA reviewed FY 2023 (rates) and FY 2024 (demographic group rates) data from the CalMHSA Dashboard. The rate for LA County (277) is lower than the State rate (372). Within LA County, different population groups experience disparities (FY 2024). Regarding sex, the rate for males (408) is above the county rate (277).

Justice Involvement – Adult Recidivism Conviction Rate

(Recidivism conviction rate refers to the percentage of individuals who reoffend after being released from incarceration.)

TCMHA reviewed FY 2019-20 data from the CalMHSA dashboard. The rate for LA County (35.9%) is below the State rate (39.6%). Within LA County, different population groups experience disparities (FY 19-20). Regarding age, 18-19 (65.6%), 20-24 (48.3%), 25-29 (45.9%), and 30-34 (41.1%) groups are above the county rate (35.9%). Regarding sex, the rate for males (36.6%) is above the county rate (35.9%). Regarding race, the Hispanic rate (38.7%) is above the county rate (35.9%).

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)

Across most domains, Tri-City is below the statewide average for justice. However, Tri-City plans to work with those involved in the criminal justice system with the following approaches. TCMHA will deliver an integrated, evidence-based continuum of behavioral health services designed to reduce recidivism, improve family functioning, and promote long-term stability for probation-involved youth. Services will include Children's Outpatient (COP), Wraparound, Substance Use Disorder (SUD) treatment, Full Service Partnership (FSP), Forensic Assertive Community Treatment (FACT), Intensive Case Management (ICM), and Individual Placement and Support (IPS).

This continuum ensures youth receive the appropriate level of care based on clinical acuity, criminogenic risk factors, and family needs.

Children's Outpatient (COP)

COP will provide individual therapy, family therapy, psychiatric evaluation, and medication management for youth with mild to moderate behavioral health needs. Services will address trauma, emotional regulation, decision-making skills, and family conflict. Functional Family Therapy (FFT) will be integrated within COP to target family-based risk factors linked to reoffending.

Wraparound Services

Wraparound will serve youth with complex, multi-system involvement. A Child and Family Team (CFT) will develop individualized service plans incorporating probation goals, educational needs, and behavioral

health interventions. Services include crisis response, intensive care coordination, and strength-based family engagement.

Substance Use Disorder (SUD) Treatment

SUD services will include screening, assessment, outpatient treatment, relapse prevention, and family education. Motivational Interviewing and cognitive-behavioral interventions will support accountability while reducing substance-related violations.

Full Service Partnership (FSP)

FSP will provide intensive “whatever it takes” services for youth with serious emotional disturbance (SED). Services include field-based support, psychiatric care, flexible funding to remove barriers, housing stabilization when necessary, and integrated care coordination to prevent detention or placement disruption.

Forensic Assertive Community Treatment (FACT)

FACT will serve TAY aged clients with high acuity mental health needs and repeated justice involvement. With small caseloads and field-based interventions, FACT will provide intensive psychiatric services, skill development, crisis intervention, and close collaboration with Probation.

Intensive Case Management (ICM)

ICM will support moderate-to-high need youth requiring structured care coordination, school advocacy, and linkage to pro-social supports. ICM bridges outpatient services and higher levels of care to maintain engagement and reduce system penetration.

Individual Placement and Support (IPS)

IPS will assist transition-age youth (TAY) in securing competitive employment through rapid job placement, employer engagement, and integrated employment planning within behavioral health treatment. Employment stability is a key protective factor against recidivism.

The following evidence-based models will be incorporated:

Multisystemic Therapy (MST): For high-risk youth, MST will provide intensive, home-based intervention addressing family, peer, school, and community systems contributing to delinquent behavior.

Functional Family Therapy (FFT): Integrated within COP and TAY services to reduce family conflict and improve communication and supervision practices.

Cognitive Behavioral Therapy (CBT)

Motivational Interviewing (MI)

Trauma-Informed Care

TCMHA will maintain structured collaboration with Probation through:

Joint case staffing and multidisciplinary team meetings t

Shared service planning aligned with court-ordered conditions

Defined communication protocols and progress reporting

Cross-training between clinical and probation staff

Compliance with confidentiality and information-sharing standards

Probation officers will be engaged as partners in rehabilitation, ensuring accountability while reinforcing therapeutic progress.

File Upload

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

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

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?
Above

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

Removal Of Children from Home: Supplemental Measures

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

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

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

TCMHA reviewed January 2025 Point in Time (PIT) rates from the CalMHSA dashboard in regard to children in foster care PIT count (per 100K). The rate for LA County (637) is above the State rate (525). Within LA County, age group disparities exist for PIT January 2025. Age groups rates for 1-2 (766) and Under 1 (706) are above the county rate.

TCMHA reviewed FY 2022 rates and FY 2021 (demographics) data from the CalMHSA Dashboards for open child welfare cases that received SMHS. The rate for LA County (48.2%) exceeds the State rate (43.0%). Within LA County, different groups experience disparities (FY 2021). The rates for age groups 0-2 (32.3%), 3-5 (44.2%), and 18-20 (39.8%) are below the County rate (50.6%). Regarding race, the rates for Other race (44.4%) and Black (49.6%) fall below the County rate (50.6%).

Removal of Children from Home – Children in Foster Care PIT Count (per 100K)

TCMHA reviewed January 2025 PIT rates from the CalMHSA dashboard. The rate for LA County (637) is above the State rate (525). Within LA County, different population groups experience disparities for children in foster care PIT count (Jan 2025). Regarding age, rates for ages 1-2 (766) and Under 1 (706) are above the county rate.

Removal of Children from Home – Open Child Welfare Case that receive SMHS

TCMHA reviewed FY 2022 rates and FY 2021 (demographics) data from the CalMHSA Dashboards. The rate for LA County (48.2%) exceeds the State rate (43.0%). Within LA County, different population groups experience disparities (FY 2021). Regarding age, the rates for groups 0-2 (32.3%), 3-5 (44.2%), and 18-20 (39.8%) are below the County rate (50.6%). Regarding race, the rate for Other race (44.4%) falls below the County rate (50.6%). Regarding sex, the rate for males (50.3%) falls below the County rate (50.6%).

Removal of Children from Home – Child Maltreatment Substantiation (per 1000)

TCMHA reviewed FY 2022 and FY 2024 (demographics) data from the CalMHSA Dashboard. The rate for LA County (6.7) is above the State rate (6.5). Within LA County, different population groups experience disparities (FY 2024). Regarding age, the rate for age group Under 1 (18.5) is above the County rate (6.4). Regarding sex, the rate for females (6.7) is above the County rate (6.4). Regarding race, the rates for Black/African American (17.3), Native American (10.2), and Hispanic (7.4) are above the County rate (6.4).

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

Tri-City's review of CALMHSA dashboard data show rates higher than the statewide average across all measures. Particularly those ages 1-2 years old. This may suggest a more comprehensive approach is needed. Tri-City will be using High Fidelity Wraparound to address these disparities for youth of all ages in the community.

TCMHA's plans for reducing the level of removal of children from home include:
Tri-City Mental Health Authority is committed to strengthening families and preventing unnecessary out-of-home placement through coordinated, trauma-informed, and culturally responsive behavioral health services. Central to this approach is the implementation of High-Fidelity Wraparound, a family-driven, team-based planning process designed to prevent removal of children from their homes, improve functioning across life domains, and ensure coordinated service delivery across systems.

High-Fidelity Wraparound emphasizes collaboration among child welfare, probation (when applicable), schools, healthcare providers, community-based organizations, and natural supports identified by the family. Through the development of individualized Child and Family Teams (CFTs), services are aligned around shared goals that address safety, permanency, and well-being. Natural supports—such as extended family members, faith-based connections, mentors, and community partners—are intentionally incorporated to promote long-term sustainability beyond formal system involvement.

To support families connected to Child Welfare, TCMHA will:
Collaborate with key partners who have direct access to youth and families involved in the child welfare system to ensure a clear understanding of available behavioral health services and referral pathways. Ongoing cross-system communication strengthens coordination and reduces service gaps.

Leverage established partnerships to engage youth and families early in the child welfare process, supporting stabilization efforts and mitigating risk factors that may contribute to placement disruption.

Facilitate timely enrollment of eligible youth into Specialty Mental Health Services to ensure access to comprehensive assessment, individualized treatment planning, and psychiatric support when indicated.

Provide coordinated referrals and active collaboration with agencies working to stabilize the family unit, including social services, housing providers, educational institutions, and community-based organizations. This ensures services are integrated rather than fragmented.

Deliver developmentally appropriate, culturally responsive, and trauma-informed care tailored to the unique strengths and needs of each youth and family. Interventions address emotional regulation, parenting capacity, attachment, and behavioral stabilization.

Integrate peer support specialists into treatment planning and service delivery. Peers with lived experience enhance engagement, build trust, and model resilience for youth and caregivers navigating the child welfare system.
Link eligible families to Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) to provide structured, in-home interventions that strengthen family functioning, reduce behavioral crises, and minimize the risk of removal or re-entry into care.

Through High-Fidelity Wraparound and coordinated cross-system collaboration, Tri-City promotes improved family functioning, enhanced caregiver capacity, increased school stability, and reduced reliance on higher levels of care. This integrated approach ensures that families receive the right services at the right time, with natural and community supports positioned to sustain long-term success.

Non Hi-Fi Wrap solutions

Early School Age programming – School based MH services

Strengthening Families to Prevent Removal

HighFidelity Wraparound focuses on stabilizing youth within their homes and communities by addressing the underlying needs that often lead to CPS involvement or placement, such as untreated mental health needs, family stress, trauma, or lack of supports.

Individualized, strengthsbased plans are developed with families, not for them.

Natural supports (extended family, faith leaders, mentors) are intentionally integrated to reduce reliance on systems.

Families receive coaching, skillbuilding, and crisis planning that increases their capacity to safely care for their children.

Coordinated, CrossSystem Collaboration

Wraparound brings together mental health, child welfare, schools, probation, and community partners into one unified team.

Shared planning prevents fragmented or duplicative services.

Early identification of safety concerns allows teams to intervene before CPS thresholds are met.

Collaboration ensures compliance with California mandates (e.g., ICC/ICT, EPSDT, Continuum of Care Reform).

Intensive, Individualized Mental Health Support

Many youth enter foster care or group homes due to untreated or escalating mental health and behavioral needs. Wraparound addresses this directly by:

Coordinating timely access to specialty mental health services.

Embedding therapeutic interventions within daily routines and natural settings.

Supporting caregivers to manage behaviors safely and effectively.

Crisis Prevention and Safety Planning

HighFidelity Wraparound includes proactive crisis and safety planning, which is critical in preventing CPS reports and placement disruptions.

Teams identify triggers early and develop clear response strategies.

Families have 24/7 access to support and crisis response resources.
Plans are regularly updated based on realtime needs.

Reducing Placement Disruptions and ReEntry into Care

For youth already involved with CPS or at risk of placement, Wraparound helps:

Stabilize foster or kinship placements.

Support reunification and prevent reentry into care.

Reduce placement changes by addressing behavioral and emotional needs holistically.

File Upload

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
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Untreated Behavioral Health Conditions: Primary Measures

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

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

For the full population measured
Below

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

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

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

For the full population measured
Below

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
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

TCMHA's Follow-up after Emergency Department Visit for Mental Illness rate (32.2%) is below the statewide rate (38.2%) and median (37.3%). Publicly available FUM equity data are not available. Rate of self-reported untreated BH needs in the county (50.4%) is slightly higher than State rate (48.4%). Rate of untreated BH needs is noticeably higher amongst 18–24-year-olds (60.2%). Slightly higher rates exist amongst males (53.9%), Asian/Pacific Islander (55.8%), and Hispanics (54.9%).

Untreated Behavioral Health Conditions - 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 – Supplemental Goal

TCMHA reviewed FY 2023 rates from the CalMHSA Dashboard. The rate for LA County (50.4%) is above the State rate (48.4%). Within LA County, different population groups experience disparities (FY 2023). Regarding age, the rate for 18-24 year olds (60.2%) is above the County rate (50.4%). Regarding sex, the rate for males (53.9%) is above the County rate (50.4%). Regarding race, the rates for Asian/Pacific Islanders (55.8%) and Hispanics (54.9%) are above the County rate (50.4%).

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)
TCMHA's plans to decrease the level of untreated behavioral health conditions involve different components. This is based on the county to statewide comparisons provided by CALMHSA.

TCMHA will establish MOUs with local hospitals to create a clear, easy pathway that ensures individuals connect to behavioral health services.

TCMHA staff (access to care team and/or MCC) will provide timely responses and contact individuals, identify appropriate behavioral health services, and provide warm hand offs to other providers (e.g., private insurance, local providers) when needed.

TCMHA staff will facilitate regular collaborative meetings with partners to address barriers and identify individuals who fail to connect to behavioral services or who have multiple ER visits related to behavioral health or substance use. Staff will outreach to, engage with, and connect individuals who meet criteria for Full-Service Partnership ACT or FACT as appropriate. FSP ACT and FACT will provide regular outreach in

community locations, homeless shelters, or spaces most appropriate and convenient for the individual. In addition, referred individuals will work with the same ACT team from outreach to treatment to help facilitate engagement, rapport, and participation in services.

Peer support staff in the FSP ACT or FACT teams will help engage and connect with all populations, specifically the chronically mentally ill and homeless. Peer staff will assist with development and implementation of solutions to improve follow-up to services.

TCMHA will ensure that all staff are trained and have access to Language Line to be able to outreach to target populations and provide services in a client's language of choice including but not limited to Spanish and Asian Pacific Islander languages.

TCMHA will leverage existing community partnerships (e.g., local universities and K-12 organizations) to bring awareness of and access to behavioral health services and reduce related stigma. TCMHA will make marketing materials available to increase mental health literacy and use peer support staff to assist in the development of marketing messaging and social media posts to increase engagement.

File Upload

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

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

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

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

For adults/older adults
Above

For children/youth
Above

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

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

For adults/older adults
Below

For children/youth
Above

Engagement In School: Primary Measures

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

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

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
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Overdoses: Supplemental Measures

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

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

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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)
Above

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

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
Below

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
Below

Suicides: Supplemental Measures

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

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

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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.
Care experience

Care experience

Please describe why this goal was selected
The goal of improving client care experience and perceptions of cultural appropriateness was selected because there is a critical need to increase client engagement and generate reliable local data to effectively monitor progress. The plan is to use local, disaggregated data to identify disparities and understand clients' perceptions of cultural appropriateness, co-design solutions with community partners, and adjust care in real time based on client feedback. Services will be culturally responsive and family-centered, with attention to clients' cultural and ethnic identities, LGBTQ+ status, age, family context, and gender-specific needs. TCMHA will monitor access, retention, and client-reported outcomes using clear, measurable indicators.

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
Although countywide data do not indicate a significant disparity, local findings suggest opportunities to strengthen cultural responsiveness and client connectedness. In the May 2025 LACDMH Treatment Perception Survey, 90% of adults and 79% of youth reported that staff were sensitive to their cultural background; however, no disaggregated local data are currently available. In contrast, results from a TCMHA client survey indicate that meaningful improvements in culturally responsive care are still needed. To address these gaps, TCMHA will establish a baseline using its survey data and implement targeted strategies, including increasing clinical staffing levels, expanding therapy appointment availability, enhancing staff training to improve treatment quality, and implementing continuity-of-care protocols to ensure clients consistently see the same providers.

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 Care experience 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)
To advance this Care Experience goal and increase perception of cultural appropriateness, TCMHA will use local, disaggregated data to identify gaps, set targets, and guide continuous improvement. Specifically, TCMHA will (1) analyze local data on access, engagement, and discharge by race/ethnicity, language, sexual orientation and gender identity (SOGI), and age bands; (2) synthesize themes from client experience surveys

and grievances/appeals to determine pain points in navigation and cultural responsiveness; and (3) monitor retention-in-care and no-show trends to inform and direct outreach. Within treatment, staff will deploy a feedback-informed approach that captures brief, session-by-session client-reported outcome and experience measures (e.g., wellbeing and alliance scales) so clinicians can tailor care in real time, escalate support when scores flag risk, and close the loop with clients and families. All services will be culturally responsive and person- and family-centered, explicitly attentive to each client's cultural and ethnic identity, LGBTQ+ status, age, family context, and gender-specific needs. Together, local data, community partnership, and real-time client feedback will help TCMHA deliver care that is equitable, trustworthy, and effective for the people the agency serves.

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

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

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

Stakeholder Engagement

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

---

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

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

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

Attending community partner events, community meetings to enhance reciprocity of the relationships, touring community partner locations through immersive visits.

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

Type of engagement

County outreach through social media

Date
1/10/2025

Type of engagement
County outreach through social media

Date
5/17/2025

Type of engagement
County outreach through townhall meetings

Date
1/29/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
1/1/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
5/22/2025

Type of engagement
Focus group discussions

Date
3/3/2025

Type of engagement
Focus group discussions

Date
3/6/2025

Type of engagement
Focus group discussions

Date
3/22/2025

Type of engagement
Focus group discussions

Date
3/25/2025

Type of engagement
Focus group discussions

Date
3/26/2025

Type of engagement
Key informant interviews with subject matter experts

Date
8/6/2025

Type of engagement
Key informant interviews with subject matter experts

Date
8/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/17/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/1/2025

Type of engagement
Meeting(s) with county

Date
8/18/2025

Type of engagement
Meeting(s) with county

Date
11/10/2025

Type of engagement
Provided data to county

Date
8/18/2025

Type of engagement
Provided data to county

Date
11/10/2025

Type of engagement
Public e-mail inbox submission

Date
10/29/2025

Type of engagement
Survey participation

Date
3/6/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/28/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/29/2025

Type of engagement
Training, education, and outreach related to community planning

Date
2/5/2025

Type of engagement
Training, education, and outreach related to community planning

Date
2/23/2025

Type of engagement
Training, education, and outreach related to community planning

Date
3/19/2025

Type of engagement
Training, education, and outreach related to community planning

Date
5/27/2025

Type of engagement
Workgroups and committee meetings

Date
7/15/2025

Type of engagement
Workgroups and committee meetings

Date
8/19/2025

Type of engagement
Workgroups and committee meetings

Date
9/16/2025

Type of engagement
Workgroups and committee meetings

Date
10/21/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
The community planning process involved organizations such as Compassionate Pomona, La Nueva Voz, Brownstone Mentoring Services, Community Research Translational Initiative (CRTI), City of Pomona, Lion's Club, House of Ruth, Bonita Unified School District, Pomona Unified School District, National Alliance on Mental Illness (NAMI), Police Department, World Peace Now, Pomona Valley Hospital Medical Center (PVHMC), University of La Verne, Meals on Wheels, Community Action for Peace, University Club of Claremont, League of Women Voters, Pomona Community Life Commission, the Immigrant Integration and Inclusion Grant, and Hope for Housing.

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

	City name
1	n/a
2	n/a
3	n/a
4	n/a
5	n/a

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?
Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
Labor representative organizations
Local public health jurisdictions
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.)

Labor representative organizations
Stakeholder group is not applicable to county

Local public health jurisdictions
Stakeholder group is not applicable to county

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

Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
Attempted but did not receive a response

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

To ensure diverse community input, a variety of inclusive engagement strategies were implemented throughout 2025:

January Community Forum: Hosted at a community partner location and open to all stakeholders, including staff, partners, clients, and community members.
Community Planning Process Survey: Open from March to June 2025, this survey gathered broad input on community needs and priorities.
March Focus Groups: Targeted outreach to culturally diverse and historically marginalized populations to ensure equitable representation.
MHSA to BHSA Workgroups: Held from July 2025 and running until June 2026, these workgroups facilitated deeper dialogue and planning among stakeholders.
Community-Identified Strengths-
Participants consistently highlighted the Tri-City Mental Health Authority as a community asset, citing its:
Robust programs
Frequent community forums and events
Broad opportunities for engagement and support
Community-Identified Priorities-
Key themes emerged across engagement efforts:
Housing: A critical need for increased housing development and services for individuals experiencing homelessness.
Workforce Development: Emphasis on strategies to support, develop, and retain a strong behavioral health workforce
While we were unable to connect with labor representative organizations, the agency was still able to gather meaningful worker perspectives during our community planning process by using alternative methods to hear directly from workers and from groups that understand their experiences. Tri-City engaged workers through listening sessions, surveys, focus groups, and pop-up outreach at community hubs and events. Tri-City relies on ongoing advisory groups that include workers who are active in broader community networks—such as faith communities, cultural organizations, and neighborhood associations—ensuring that a wide range of lived experiences informs our planning efforts.
Although Local public health jurisdictions were not specifically engaged, Tri-City plans to expand our connection with the local public health department and meaningfully incorporate their perspective into future community planning by treating them as a core partner rather than an outside stakeholder. Public health staff can help frame issues, identify vulnerable populations, and highlight health impacts that might otherwise be overlooked. Their data—covering chronic disease, air quality, walkability, food access, emergency response, and other social determinants of health—can guide our priorities and clarify who benefits or is burdened by planning decisions. Tri-City intends to include them in cross-sector working

groups, advisory committees, and joint workshops, so their expertise is integrated into key discussions. Tri-City also recognizes their strong relationships with hospitals, clinics, schools, and community-based organizations, which means partnering with them expands our reach into populations that may be harder to engage directly.
While we could not identify a local Tribal and Indian Health Program designee established for Medi-Cal Tribal consultation purposes, Tri-City can still incorporate Tribal and Indian Health perspectives in our planning process. Tri-City can consult nearby Tribal governments, Indian Health Service regional offices, Urban Indian Health Programs, and state Tribal liaison offices to understand cultural priorities, health needs, and community concerns. Tri-City can also gather input directly from Indigenous residents through listening sessions and partnerships with Native-serving nonprofits and cultural organizations. These approaches ensure Indigenous perspectives are meaningfully reflected in our planning efforts, even without a formal local representative.

Upload File

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.
Other

Please explain why or describe an alternate approach taken.
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Collaboration

Please select how the county collaborated with the LHJ
Other.

Please describe the other way the county collaborated with LHJs and MCPs in developing the CHA/CHIP

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

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

Other

Please describe

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

Was data shared?

No

Data-Sharing from MCPS and LHJs to Support IP development

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

Other

Please describe

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

Was data shared?

No

Stakeholder Activities

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

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

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
No

Please explain why the county did not consider the LHJ's CHA/CHIP or strategic plan when preparing its IP
Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

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

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

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
2/20/2026

Date the stakeholder comment period closed
3/23/2026

Date of behavioral health board public hearing on draft IP
4/14/2026

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
March 2026 La Nueva Voz BHSA Public Hearing.pdf
March 2026 Claremont Courier TCMHA BHSA Public Hearing.pdf
Website Posting.png
04-14-2026 TCMHA Notice of BHSA Public Hearing Eng-Spa.pdf
Social Media 1 PDF.pdf
Social Media 2.pdf

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

File Upload

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

Attach email
Proof of Internal Notice.pdf
Proof of External Notice.pdf

Please specify the other process the draft plan was circulated to stakeholders
Additional processes used to circulate the plan included social media, website, flyers, public announcements (city council meetings, community meetings), newspapers, and public comment during Tri-City Commission and Governing Board meetings.

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

Stakeholder group that provided feedback
Community member

Summarize the substantive revisions recommended this stakeholder during the comment period
Tri City's BHSA plan ignores the gut-brain connection, despite peer-reviewed evidence that gut health is central to mental health. By excluding nutrition and detoxification from its strategy, Tri City is failing its own mission statement and opting to "mask" symptoms rather than treat root causes. It is disappointing that a $30 million organization with significant carry-over funds would task a private citizen with policy change instead of using its own political clout to implement these essential, evidence-based health strategies.

Stakeholder group that provided feedback
Families of eligible children and youth, eligible adults, and eligible older adults

Summarize the substantive revisions recommended this stakeholder during the comment period

In the Integrated Plan both types of outreach (outreach provided by Community Navigators compared to outreach provided by Direct Link Outreach Team) were listed as only one type of outreach and Tri-City is encouraging staff to revise it for clarity.

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

This information will be provided after our 30-day public comment period, final stakeholder meetings, and Public Hearing.

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

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

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

Medical QI Plans.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	0
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

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

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

All BHSA Provider Locations

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

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

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)

No

If not, please describe how the county will monitor these providers for compliance with BHSA requirements

N/A

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
Tri-City does not contract out for any mental health services, substance use disorder services or both MH/SUD services; all services are provided by Tri-City. Therefore, there is no provider(s) contracted to monitor.

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

---

General

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

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

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

Supportive services

Please describe the specific services provided
n/a, there was no option to delete the program, so individual entries were deleted. Stigma reduction was removed under BHSS.

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	0
FY 2027 – 2028	0
FY 2028 – 2029	0

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
n/a, there was no option to delete the program, so individual entries were deleted. Stigma reduction was removed under BHSS.

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
Supportive services

Please describe the specific services provided
The Family Wellbeing program offers a wide range of activities and supports designed to meet the needs of entire families, blending support groups, one-on-one guidance and culturally relevant wellness activities such as exercise and cooking to engage caregivers and community members in meaningful, peer-supported experiences. While the program is not clinical in nature, the team is equipped to assess individuals in crisis and, when necessary, coordinate with Mobile Crisis Care team or local law enforcement

to ensure the person receives the appropriate level of care, whether through the Tri-City clinic or a hospital emergency room. Families may also be connected with additional resources through Community Navigators or Tri-City's Housing Department, creating a network of support that extends beyond immediate wellbeing activities.

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	362
FY 2027 – 2028	372
FY 2028 – 2029	384

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

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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

Supportive services

Please describe the specific services provided
Community Navigators program connects individuals and families to vital local resources. Their trained team provides referrals and linkage to services including but not limited to mental health care, legal aid, food banks, substance use treatment, support groups, parenting classes, medical support, free clothing and shoes. By collaborating with schools, law enforcement, and community-based organizations, Navigators implement a localized system of care which is responsive to the individual needs of communities, the people who receive services, and their families.

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	1359
FY 2027 – 2028	1400
FY 2028 – 2029	1442

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
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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
Supportive services

Please describe the specific services provided

Peer mentors provide supportive services by engaging in active listening, assisting individuals in identifying personal strengths and functional areas of need, assessing the types of support required, and offering guidance on appropriate resources to address those needs. Peer mentor services are provided by a culturally diverse team trained in recovery-oriented support. Using their own lived behavioral-health experience, peer mentors help individuals feel connected, offer hope, and provide guidance that supports coping skills and progress toward recovery goals. Peer Mentors aim to support individuals by Increasing their sense of connection and reduce isolation as individuals engage with a supportive peer who validates their experiences, improved self-awareness, including clearer identification of personal strengths, needs, and recovery goals, and enhance coping skills through guidance informed by the individual's lived behavioral-health experience. Mentors also support through providing recovery-oriented activities, services, and community support, increase hope, motivation, and confidence in the individual's ability to manage behavioral-health challenges, improve participants ability to identify and access appropriate resources, including clinical, social, and community support, support progress toward individualized recovery goals, supported by ongoing encouragement and strength-based interventions.

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	62
FY 2027 – 2028	64
FY 2028 – 2029	66

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

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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
Supportive services

Please describe the specific services provided
The Family Wellbeing program offers a wide range of activities and supports designed to meet the needs of entire families, blending support groups, one-on-one guidance and culturally relevant wellness activities such as exercise and cooking to engage caregivers and community members in meaningful, peer-supported experiences. While the program is not clinical in nature, the team is equipped to assess individuals in crisis and, when necessary, coordinate with Tri-City’s Mobile Crisis Care team or local law enforcement to ensure the person receives the appropriate level of care, whether through the Tri-City clinic or a hospital emergency room. Families may also be connected with additional resources through Community Navigators or Tri-City’s Housing Department, creating a network of support that extends beyond immediate wellbeing activities.

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	362
FY 2027 – 2028	372
FY 2028 – 2029	384

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
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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
Supportive services

Please describe the specific services provided
The Therapeutic Community Garden (TCG) is designed to promote mental wellness and decrease isolation. The program will serve Transition-Age Youth (TAY) and Adults and Older Adults residing in the three designated cities of Pomona, Claremont, and La Verne via structured therapeutic horticulture programming in a safe, inclusive, and recovery-oriented environment. Through nature-based activities, psychoeducational workshops, and peer-supported group engagement, participants will strengthen protective factors that support emotional resilience and overall well-being. Programming will also decrease social isolation by fostering meaningful social connections, intergenerational engagement, and community engagement. Participants will develop practical coping and healthy lifestyle skills through facilitated sessions focused on mindfulness, stress management, emotional regulation, and problem-solving. Additionally, TCG will increase access to services by providing direct linkages and warm handoffs to behavioral health and supportive services within TCMHA, including outpatient care, case management, peer support, and other appropriate levels of care.

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	4036

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	1216
FY 2028 – 2029	4282

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

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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

Supportive services

Please describe the specific services provided

The Tri-City Wellness Center serves as a welcoming community space where people of all ages can access free services that support mental health recovery, resilience and overall wellness. Visitors are greeted by trained staff, peer advocates, volunteers and clinicians who foster a sense of belonging and encourage personal growth for individuals and families. Supported by highly trained staff and strong community partnerships, the center offers a wide range of holistic resources that promote independence and well-being, including peer support groups, family and youth services, employment and educational assistance, computer access, recreational and culturally responsive activities, as well as assessment, referral and linkage to additional supports.

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	3312
FY 2027 – 2028	3411
FY 2028 – 2029	3513

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
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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
Access to Care

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

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

Please select the EBPs and CDEPs that apply

Acceptance and Commitment Therapy (ACT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Peer Support Services (* Acceptance and Commitment Therapy (ACT) was selected above in order to circumvent a glitch, we are not utilizing ACT, only Peer Support Services)

Please describe intended outcomes of the program or service

The Access to Care Program serves as the centralized entry point for TCMHA's services Act Early Intervention (PEI) services. In accordance with PEI requirements, the program is designed to prevent mental health and substance use disorders from becoming severe and disabling, reduce behavioral health disparities, and promote timely access to culturally and linguistically responsive care.

Services are delivered across the lifespan, including children, adolescents, transition-age youth, adults, and older adults. The multidisciplinary Access Team conducts timely, trauma-informed, and culturally responsive assessments to identify early signs and symptoms of mental health and substance use concerns, assess risk and functional impairment, and determine appropriate level of care. Interpretation and translation services are available to ensure meaningful access for individuals and families with limited English proficiency and to advance health equity.

Consistent with PEI principles of early identification and rapid linkage, the program ensures expedited access to the least restrictive, community-based services appropriate to individual need. The team provides direct linkage to outpatient mental health and substance use treatment, early psychosis and youth-focused services, school-based supports, services for older adults, prevention programs, and recovery supports. When urgent needs are identified, the program coordinates same-day or priority appointments to reduce delays in care and prevent escalation.

The Access to Care Program strengthens system coordination and continuity by supporting appropriate placement, facilitating step-up or step-down transitions, and addressing social determinants of health through linkage to primary care, housing, food resources, and peer and family supports. Through proactive engagement, equity-driven practices, and rapid connection to services, the program advances BHSA/PEI goals of prevention, early intervention, and long-term wellness for individuals and families across the lifespan.

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	2964
FY 2027 – 2028	3053
FY 2028 – 2029	3145

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

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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

Mobile Crisis Care

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

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
Acceptance and Commitment Therapy (ACT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Peer Support Services (* Acceptance and Commitment Therapy (ACT) was selected above in order to circumvent a glitch, we are not utilizing ACT, only Peer Support Services)

Please describe intended outcomes of the program or service
TCMHA's Mobile Crisis Care team provides 24/7 phone and field-based behavioral health crisis response. Services are trauma-informed, culturally responsive, and include interpretation and translation to ensure meaningful language access for all individuals served. While available across the lifespan, services prioritize children, adolescents, and young adults age 25 and under, with focused language-accessible support and coordination in school settings to promote early identification and intervention.
The team responds in pairs, with designated TCMHA clinicians, or in co-response with law enforcement when appropriate.
Aligned with BHSA Early Intervention principles, Mobile Crisis Care emphasizes rapid access, de-escalation, and linkage to the least restrictive, community-based services to prevent escalation and reduce unnecessary hospitalization. The team strengthens natural supports, connects individuals to ongoing behavioral health treatment, and links families to essential resources including food, healthcare, and housing.
Proactive outreach targets youth and young adults (25 and under) in schools and community settings through screening, psychoeducation, and culturally and linguistically responsive engagement. Following critical incidents, the team provides outreach and debriefings to promote recovery and increase awareness of available behavioral health services.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	93
FY 2027 – 2028	96
FY 2028 – 2029	99

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

Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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

Peer Mentor Tay Wellbeing

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

Outreach

Access and Linkage: Other

Please specify "other" type of Access and Linkage

Peer mentors provide supportive services by engaging in active listening, assisting individuals in identifying personal strengths and functional areas of need, assessing the types of support required, and offering guidance on appropriate resources to address those needs.

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

Peer mentor services are provided by a culturally diverse team trained in recovery-oriented support. Using their own lived behavioral-health experience, peer mentors help individuals feel connected, offer hope, and provide guidance that supports coping skills and progress toward recovery goals. Peer Mentors support participants with increasing sense of connection and reduce isolation as individuals engage with a supportive peer who validates their experiences, improved self-awareness, including clearer identification of personal strengths, needs, and recovery goals, enhance coping skills through guidance informed by the individual's lived behavioral-health experience. Peer Mentors support aims to increase participants engagement in recovery-oriented activities, services, and community support, lead to increased hope, motivation, and confidence in the individual's ability to manage behavioral-health challenges, improve ability to identify and access appropriate resources, including clinical, social, and community support, increase progress toward individualized recovery goals, supported by ongoing encouragement and strength-based interventions.

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	251

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	259
FY 2028 – 2029	266

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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
Community Wellbeing Grants

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

Please specify "other" type of Access and Linkage
The Community Wellbeing Grant program provides grantees and their communities the knowledge and information needed regarding the process of seeking an assessment when appropriate. Grantees are equipped with understanding of screening, intake and assessment processes and refer as needed to Tri-City or other resources as needed.

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

Please describe intended outcomes of the program or service
The Community Wellbeing Grants aim to strengthen the capacity of local communities to increase social connection and mental wellbeing. The program builds upon the knowledge and valuable experience of local communities and supports them to accomplish their goals in a manner they see fit for their community. Mental and emotional wellbeing of their members are enhanced by the program providing ongoing guidance and support from Tri-City staff to achieve project goals, technical assistance to collect and receive data from their community and evaluate their project's impact. The program promotes increased awareness of mental health and wellbeing within grantees communities, including providing numerous opportunities to network and share with other local communities, access to evidence-based mental health and trauma-informed training, and connection to resources.

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	8473
FY 2027 – 2028	8727
FY 2028 – 2029	8989

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Data from the previous fiscal year (24-25) was used to determine the number of people served and to project for upcoming fiscal years. Growth for each year was estimated with a 3% increase.

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
First Episode Psychosis

CSC program description
The First Episode Psychosis (FEP) program is a Coordinated Specialty Care (CSC) initiative focused on providing early intervention for individuals experiencing their first episode of psychosis. This multidisciplinary, recovery-oriented program serves youth and young adults ages 12 to 40 who are within the first two years of the onset of psychotic symptoms. Services are grounded in evidence-based practices, including medication management, supported education and employment (SEE), cognitive behavioral therapy for psychosis (CBT), family education and support, and case management. The program emphasizes shared decision-making and cultural responsiveness and prioritizes community integration and reduction of long-term disability associated with psychosis.
Referrals come from emergency departments, primary care, schools, behavioral health providers, and families. Outreach and engagement strategies include psychoeducation, peer support, and mobile assessment. The program is currently co-located with other youth services and collaborates with county and community-based organizations to ensure continuity of care.
*Tri-City estimated numbers for CSC Eligible Population-Number of Medi-Cal Enrolled Individuals, to be 32 based on being 2% of the Los Angeles County population
*Tri-City estimated numbers for CSC Eligible Populations- Number of Uninsured Individuals, to be 4 based on being 2% of the Los Angeles County population
*Tri-City estimated numbers for CSC Practitioners and Teams Needed-Number of Practitioners Needed to Serve Total Eligible Population, to be 4 based on being 2% of the Los Angeles County population
*Tri-City estimated numbers for CSC Practitioners and Teams Needed-Number of Teams Needed to Serve Total Eligible Population, to be based on being 2% of the Los Angeles County population

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	1604
Number of Uninsured Individuals	218

CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	196
Number of Teams Needed to Serve Total Eligible Population	46

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

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	4	5	5
Total Number of Teams	1	1	1

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

Outreach and Engagement (O&E) Program

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

Program or activity name
Direct Link Outreach

Please describe the program or activity
The Direct Treatment Link Outreach Team is designed to advance the core goals of the Behavioral Health Services Act (BHSA) by promoting early intervention, prevention, and equitable access to behavioral health services across the lifespan. The program aligns with BHSA priorities by emphasizing community collaboration, cultural responsiveness, and client- and family-driven care. Through proactive engagement and coordinated service delivery, the program seeks to reduce disparities, strengthen system navigation, and improve behavioral health outcomes for vulnerable and underserved populations. TCMHA will implement a multidisciplinary, field-based outreach and engagement model that provides a direct pathway

to assessment, treatment, recovery, and supportive services. The Direct Treatment Link Outreach Team is comprised of clinical and supportive services staff, including Full-Service Partnership (FSP) clinicians, housing specialists, substance use disorder (SUD) counselors, behavioral health clinicians, crisis staff, and certified peer support specialists. This integrated team approach ensures individuals receive timely screening, warm handoffs, and coordinated linkage to the most appropriate level of care, consistent with BHSA's early intervention and prevention framework.

Outreach activities will include community-based engagement events, behavioral health education workshops, school and campus presentations, participation in health fairs, and targeted field outreach in high-need areas. Events will focus on early identification of behavioral health needs, stigma reduction, psychoeducation, and direct connection to services. TCMHA will collaborate with community-based organizations, local school districts, colleges, senior centers, hospitals, law enforcement, and other partners to expand access points and ensure broad community reach.

Target Populations include Early Childhood (Ages 0–5): Families with young children at risk of developmental, social-emotional, or behavioral health concerns, with an emphasis on early identification and family-centered support, Out-of-School and Secondary School Youth: Adolescents and young adults experiencing barriers to education, employment, or behavioral health services, including those at risk of system involvement, Older Adults: Individuals experiencing social isolation, co-occurring mental health and substance use challenges, and/or housing instability, Adults at Risk of Homelessness: Individuals with complex stressors, including co-occurring substance use and mental health conditions and LGBTQA+ Community Members: Individuals experiencing behavioral health disparities and barriers to culturally affirming care.

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	1037
FY 2027 – 2028	1068
FY 2028 – 2029	1100

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

Since this will be a new program, Tri-City used numbers from 2024 and 2025 and estimated the number of individuals who would need additional outreach and engagement at the time-of-service request. 3% growth was added to the total number of clients for fiscal years 26/27, 27/28 and 28/29.

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
Relias

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

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Funding for Relias Training, which provides online accredited continuing education for our staff, offers multiple courses focused on cultural humility, and multicultural care, which help employees understand and respect differences in cultural norms, communication styles, and worldviews. This directly supports a more inclusive environment where diverse staff feel valued and understood. Courses such as Diversity, Equity, and Inclusion for the Healthcare Worker teach strategies to identify and mitigate personal biases and communicate effectively with individuals from diverse backgrounds.
Training on working with culturally diverse colleagues helps staff navigate cultural differences that can otherwise lead to conflict or miscommunication.

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
Service Learner Program

Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Tri-City's Service Learning Program offers hands-on, community-based experience in real behavioral health settings, helping diversify the future workforce by removing many of the traditional barriers that prevent people from entering the field. By working directly alongside clinicians, peer specialists, outreach teams, and administrative staff, participants gain exposure to a wide range of behavioral health roles—often discovering career paths they may not have previously known about or viewed as attainable.
Because the only requirement for participation is a connection to the Tri-City service area (Claremont, La Verne, or Pomona), the program naturally draws from communities that are racially and ethnically diverse. This local, inclusive recruitment approach expands opportunities for individuals from groups historically underrepresented in behavioral health professions and strengthens a workforce that better reflects the community it serves.

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
Working Independent Skills Helping (WISH) Program

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
The W.I.S.H. Program helps reduce disparities in the behavioral health workforce by supporting clients who are graduating from full time services and preparing them for meaningful roles. The program intentionally recruits diverse community members—especially those with lived experience—and provides them with free, culturally responsive, community-based training that removes many of the financial and educational barriers that often limit access to behavioral health careers. By offering structured pathways into peer and behavioral health roles, W.I.S.H. empowers former clients to transform their lived experience into professional expertise. In doing so, the program strengthens local workforce capacity and builds a more representative, community-rooted behavioral health workforce.

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
Community Mental Health Training

Please select which of the following categories the activity falls under
Other

Please define the other activity
Community Mental Health Training (CMHT) program offers free, evidence-based education to residents and community partners in Claremont, La Verne, and Pomona. These programs aim to build resilience, increase mental health awareness, and educate community members. Training offered include but are not limited to Mental Health First Aid (MHFA), Community Resiliency Model (CRM), Motivational Interviewing (MI), Adverse Childhood Experiences (ACEs), and Know the Signs. Sessions can be modified to meet specific group needs and are available as monthly webinars or in-person presentations. A practical focus of self-care strategies, trauma-informed practices, and tools for supporting friends and family are embedded in presentations.

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
Tri-City's community mental health trainings are intentionally structured to equip local residents—particularly those from historically marginalized groups—with the knowledge, confidence, and practical exposure needed to enter or advance within the behavioral health field. Because these trainings are free, low-barrier, and offered directly within the community, they function as a powerful tool for promoting equity and expanding access to behavioral health career pathways.
The program provides accessible, no-cost trainings such as Mental Health First Aid, ACEs, and trauma-informed care, none of which require prior education or professional credentials. This approach opens doors for individuals who may lack the financial resources or academic background typically needed to pursue traditional behavioral health roles.
Tri-City also ensures that training content is culturally responsive and reflective of the diverse communities it serves. When participants see their own cultures, languages, and lived experiences represented, they are more likely to view themselves as capable of contributing to the behavioral health workforce.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Electronic Health Record

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Data exchange and interoperability
Electronic health record system
Monitoring
Telemedicine

Please describe the project
The primary goal of implementing a new EHR is to increase the organization's ability to track, manage, and analyze program data while reducing administrative burden and improving care coordination. As programs grow in volume and complexity, manual or fragmented systems limit visibility into service utilization, staff productivity, outcomes, and funding requirements. A robust EHR addresses these gaps by integrating clinical, operational, and reporting functions into a single system that currently does not exist.

A new EHR tailored for mental and behavioral health will enhance the organization's capacity in several critical areas:

1. Program and Service Tracking

Real-time tracking of client enrollment, attendance, service intensity, and discharge outcomes

Ability to differentiate and monitor multiple programs (e.g., various outpatient programs, case management, housing, outreach, crisis services, group services)

Standardized documentation across programs to ensure consistency and quality

2. Clinical/Non-Clinical Documentation and Care Coordination

Streamlined intake, assessments, treatment plans, progress notes, and discharge plans

Support for evidence-based practices and individualized treatment planning

Improved communication and continuity of care among clinicians, supervisors, and support staff

Case Coordination across multiple programs e.g. Initial Access service outreach, clinical programs, Billable non billable programs, Employment Services, Housing services, etc.

Integrated built in telehealth for all providers

Telemedicine and prescription management for Medical staff

3. Data, Reporting, and Outcomes Measurement

Customizable reports to track program performance, client outcomes, and service trends

Improved capacity to meet funder, grant, and regulatory reporting requirements

Data-driven decision-making to support program development, quality improvement, and strategic planning

4. Compliance and Risk Management

Built-in safeguards to support HIPAA compliance and data security

Audit trails and standardized workflows to reduce documentation risk

Support for licensing, accreditation, and payer requirements

5. Workforce and Operational Efficiency

Improved scheduling, productivity tracking, and workload management

Reduced duplication of data entry and paperwork

More efficient onboarding and supervision of new staff as the organization grows

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Human Resources Integrated System (HRIS)

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Data warehouse
Monitoring

Please describe the project
Adding a fully integrated Human Resources Information System (HRIS) as strategic infrastructure is essential to organizational sustainability, compliance, quality of care, and financial health.

1. Managing Growth Across Multiple Programs and Divisions

We operate multiple, distinct programs (e.g., outpatient services, clinic-based services, crisis intervention, school-based services, case management, housing services), each with unique staffing models, credentialing requirements, productivity expectations, and funding sources.

A robust HRIS enables:

Centralized employee records while allowing program level differentiation

Clear tracking of staff assignments across multiple programs or cost centers

Consistent HR policies with flexibility for program specific workflows

Visibility into staffing capacity, vacancies, and turnover by program or division

2. Integration with Payroll and Finance for Accuracy and Compliance

Mental health organizations rely heavily on precise payroll and financial alignment, particularly when:

Staff split time across programs or grants

Billing and reimbursement depend on staff credentials or licensure

Funding sources require detailed labor cost reporting

An integrated HR–Payroll–Finance system allows:

Automatic synchronization of employee status, pay rates, and job changes

Accurate allocation of labor costs by program, grant, or funding stream

Reduced payroll errors and compliance risk

Realtime financial reporting tied directly to workforce data

This integration is critical for audit readiness, grant compliance, and informed financial decision making.

3. Advanced Data Analysis and Cross-referencing Capabilities

As organizations grow, leadership needs more than static reports—they need actionable insights.

A modern HRIS supports:

Cross referencing HR, payroll, and finance data to analyze true program costs

Workforce analytics on turnover, retention, overtime, and vacancy trends

Diversity, equity, and workforce demographic reporting

Forecasting staffing needs based on service demand and growth projections

These capabilities allow leadership to move from reactive problem solving to strategic workforce planning.

4. Program Specific Performance Management and Goal Setting

Performance management in a mental health organization cannot be onesizefitsall. Clinicians, supervisors, program managers, and administrative staff all require different performance frameworks aligned with their roles and program goals.

An integrated HR system enables:

Multiple performance management models within one platform

Program specific goals tied to clinical outcomes, productivity, or quality metrics

Individual and team based goal setting aligned with organizational strategy

Continuous feedback, not just annual evaluations

This ensures accountability while respecting the clinical, ethical, and operational differences across programs.

5. Built-in Clinical Supervision and Management Models

Supervision is foundational in mental health services—for quality of care, staff development, and regulatory compliance. A robust HRIS can embed supervision directly into workforce management.

Key capabilities include:

Tracking of supervisory relationships and ratios

Documentation of clinical and administrative supervision sessions

Monitoring licensure, certification, and supervision hours

Linking supervision outcomes to performance reviews and professional development plans

Embedding supervision within the HR system strengthens clinical governance and supports staff growth while reducing risk.

6. Supporting Workforce Wellbeing and Retention

Burnout and turnover are persistent challenges in mental health organizations. An integrated HR system supports proactive retention strategies by:

Identifying workload imbalances and overtime patterns

Tracking professional development and career progression

Supporting equitable supervision and performance feedback

Providing data to inform wellness, engagement, and retention initiatives

This is not only an HR concern—it directly impacts continuity of care and client outcomes.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Financial Management System

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Data exchange and interoperability
Monitoring
Other

Please describe the other focus area of the project
Financial Management System

Please describe the project
As a growing mental health agency, our organization now operates multiple programs supported by diverse funding streams, including government contracts, grants, insurance reimbursements, and other restricted funds. This growth has increased the complexity of our financial operations, compliance requirements, and reporting obligations.

An integrated financial system would allow for program- and department-specific budgeting, forecasting, and tracking, ensuring that expenses and revenues are accurately aligned with funding requirements and organizational goals. Our agency operates a complex billing environment that includes multiple payer types and reimbursement methodologies. Financial data must align precisely with clinical services documented in the Electronic Health Record (EHR). Currently, limited system integration requires manual data transfers and reconciliations. An integrated financial system that "speaks" directly with the EHR and billing systems would enable:

Automated revenue recognition and reconciliation

Improved accuracy between clinical services and financial records

Faster billing cycles and improved cash flow

Stronger audit trails and compliance support

An integrated solution would link payroll, benefits, and staffing data directly to financial reporting and program budgets.

Need for Robust Budgeting, Forecasting, and Financial Controls

A modern integrated financial system supports:

Multi-year and grant-based budgeting

Real-time budget-to-actual comparisons

Program and department-level projections

Scenario modeling for funding changes or program expansion

These capabilities are essential for leadership to make informed strategic decisions, respond proactively to funding changes, and plan for sustainable growth. Our current system's limitations restrict our ability to forecast accurately and manage financial risk.

Standard Accounting and Bookkeeping Requirements

As a Joint Powers Authority, we must maintain rigorous accounting and bookkeeping practices, including:

General ledger management

Accounts payable and receivable

Fund and grant accounting

Audit-ready documentation

An upgraded integrated system would streamline these processes, reduce manual workarounds, and strengthen internal controls—supporting both operational efficiency and fiduciary responsibility. An integrated financial system would provide standardized, customizable monthly reports and on-demand data access, improving transparency, accountability, and organizational decision-making.

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	29452
Number of Uninsured Individuals	5027

Total Adult FSP Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	9615

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	3817
Number of Uninsured Individuals	652

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	1909
Number of Uninsured Individuals	326

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	680
Number of Teams Needed to Serve Total Eligible Population	68

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	17	25	30
Total Number of Teams	2	3	3

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	23726
Number of Uninsured Individuals	4049

FSP ICM Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	1115
Number of Teams Needed to Serve Total Eligible Population	223

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	44	46	47

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	6	7	7

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	30
Number of Uninsured Individuals	0

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	12
Number of Teams Needed to Serve Total Eligible Population	1

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

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	12	13	16
Total Number of Teams	3	4	5

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	43105
Number of Uninsured Individuals	7644

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	3173
Number of Teams Needed to Serve Total Eligible Population	1269

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	3	3	3
Total Number of Teams	2	2	2

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

TCMHA plans to utilize practitioners who are cross-trained in multiple EBPs to serve participants across different evidence-based modalities as appropriate. This approach allows for flexibility in addressing the complex behavioral health needs of participants. To maintain fidelity to the respective EBPs, practitioners will receive ongoing supervision, training, and support to ensure effective delivery of various interventions. EBP's will include Assertive Community Treatment, Forensic ACT, Coordinated Specialty Care for First Episode Psychosis, Individual Placement and Support, Multisystemic Therapy, Functional Family Therapy, High Fidelity Wraparound and Parent Child Interaction Therapy.

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

TCMHA's FSP program implements a whole-person, trauma-informed approach by focusing on mental health, physical health, social supports, housing stability, and engaging clients in a supportive care planning process. Teams actively engage family members, caregivers, and natural supports in treatment planning and decision making. Care coordination prioritizes understanding of participants' lived experiences, cultural context, and trauma history to determine and provide personalized, strength-based care.

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

TCMHA is committed to reducing disparities through targeted outreach to identified communities and historically underserved populations in Pomona, La Verne, and Claremont. Strategies include culturally and linguistically competent services and resources such as traditional healers when available, bilingual bi-cultural staff, partnerships with community-based organizations, and data-driven monitoring to identify and address inequities in access, engagement, and outcomes.

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

Access to care

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

FSP ICM teams conduct regular, proactive outreach including home visits, community-based engagement, and flexible appointment scheduling. Teams maintain continuous contact to ensure participants remain connected to services and support and adhere to individualized care plans. Mobile Crisis Care (MCC) services will be utilized to address urgent and emergent needs of individuals.

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
Beyond standard EBP requirements, teams provide additional engagement through peer support specialists, wellness checks, and community resource navigation to address social determinants of health and encourage sustained recovery.

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.)
TCMHA will comply by basing the appropriate number of new ACT and FACT teams on data and maintaining FSP ICM teams for participants who require intensive, flexible support. Staffing, training, and supervision structures will align with state guidelines for level of care. TCMHA will utilize level of care tools to appropriately place individuals in programs and ensure smooth transitions in treatment.

Please indicate whether the county FSP program will include any of the following optional and allowable services
Please see 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
Outreach activities will include collaboration with local clinics, shelters, and community organizations in Pomona, La Verne, and Claremont. Teams will conduct field visits, participate in community events, and leverage peer networks to engage eligible participants. There will be a Direct Link to Care Outreach with providers on FSP outreaching to potential participants.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
The FSP program will offer recovery-oriented services such as peer mentoring, wellness and life skills offered in individual and group formats, vocational support, and structured recreational activities to promote social inclusion and holistic recovery.

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
TCMHA reviewed local juvenile justice data, conducted stakeholder meetings with probation and youth-serving agencies through its Behavioral Health Student Services Act (BHSSA) program, and integrated best practices to tailor FSP services for youth at risk of justice system involvement.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
TCMHA engaged LGBTQ+ advocacy groups and community stakeholders, including local schools and universities to ensure FSP services are culturally competent, affirming, and sensitive to the unique challenges faced by LGBTQ+ youth. TCMHA has a long-standing partnership with Pomona Valley Pride.

In the child welfare system
FSP program planning included data review, collaboration with child welfare agencies, and consultations with caseworkers to address the specific behavioral health needs of youth in foster care or under child protective services supervision.

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
TCMHA analyzed demographic and service utilization data, engaged senior advocacy groups, and coordinated with geriatric mental health providers to identify effective strategies for serving older adults.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Stakeholder engagement included consulting with LGBTQ+ adult organizations such as Pomona Valley Pride and community leaders to inform program design and training staff in culturally responsive, inclusive, and affirming care practices.

In, or are at risk of being in, the justice system
TCMHA reviewed criminal justice data, held focus groups with formerly incarcerated individuals, and partnered with probation and reentry programs to develop strategies that address behavioral health needs and reducing recidivism among justice-involved adults.

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
n/a, as there are no current programs

Program descriptions
n/a, as there are no current programs

Current funding source
n/a, as there are no current programs

BHSA changes to existing programs to meet BHSA requirements
n/a, as there are no current programs

Expected timeline of operation
n/a, as there are no current programs

Mobile-field based programs

Existing programs
n/a, as there are no current programs

Program descriptions
n/a, as there are no current programs

Current funding source
n/a, as there are no current programs

BHSA changes to existing programs to meet BHSA requirements
n/a, as there are no current programs

Expected timeline of operation
n/a, as there are no current programs

Open-access clinics

Existing programs
n/a, as there are no current programs

Program descriptions
n/a, as there are no current programs

Current funding source
n/a, as there are no current programs

BHSA changes to existing programs to meet BHSA requirements
n/a, as there are no current programs

Expected timeline of operation
n/a, as there are no current programs

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Assertive field-based initiation program

Program descriptions
TCMHA will deploy a multidisciplinary, assertive field-based initiation program designed to proactively engage individuals living with substance use disorder (SUD), particularly those experiencing homelessness, justice involvement, or frequent emergency system utilization. Outreach teams will include peer support specialists, community health workers, and licensed clinicians who conduct regular field visits in encampments, shelters, transit hubs, and other high-need areas.
The program will facilitate rapid access to medications for addiction treatment (MAT) by offering same-day assessment and immediate linkage to care. Field teams will be equipped with mobile technology to conduct screenings, verify eligibility, and directly schedule appointments at partnering clinics. When clinically appropriate, buprenorphine induction may be initiated in the field or via telehealth connection to waivered providers. Transportation assistance, appointment reminders, and warm handoffs will ensure continuity of care.
Outreach strategies are informed by multiple data sources, including:
• Homeless Management Information System (HMIS) data identifying high-utilization individuals and encampment locations
• Emergency Medical Services (EMS) overdose call data and naloxone deployment reports
• Emergency department and hospital discharge data related to SUD
• Law enforcement and first responder incident data
• Community-based organization (CBO) referrals and lived-experience input from peer staff
Based on LAHSA's dashboards PIT homeless count 2025, there are 651 homeless individuals in the three

cities including categories of sheltered (staying in a temporary shelter), unsheltered no dwelling, and dwellings (assuming at least one person per dwelling).For SUD, used 1 in 10 that DHCS sites the California Health Care Foundation https://www.dhcs.ca.gov/BHT/Pages/Fact-Sheet-Prop-1.aspx Used 1/10 for California Medi-Cal Beneficiaries it's 3,843 0-25 individuals and 6,939 26+ years total of 10, 781

Planned funding

FSP

Planned operations

TCMHA will implement Targeted Outreach through an ACCESS Anywhere Recovery combined team model sized to meet community need. Given community size, the ACCESS Anywhere Recovery combined team will provide Mobile Clinic, Assertive Field-Based services, and Open Access as integrated components of the overall service approach.

Staffing will include SUD counselors, peer support specialists, and psychiatric prescribers. The team will deploy to high-need locations (encampments, shelters, drop-in sites, syringe service programs, and medication/mobile narcotic treatment sites) to deliver harm reduction supplies, brief interventions, engagement, and linkage to treatment and supportive services.

A shared referral and follow-up workflow will be established with community partners (e.g., hospitals, EMS, law enforcement, schools, and other providers) to enable real-time referrals following overdose events and facilitate rapid engagement and warm handoffs.

TCMHA will maintain a structured, bidirectional referral process with community partners (e.g., hospitals/EDs, primary care clinics, syringe service programs, shelters, schools, and justice partners) to support warm handoffs into Open Access and rapid follow-up after overdose events.

Expected timeline of implementation

Timeframe

Targeted Outreach – Key Activities

April–May 2026

Finalize program design, service hours/coverage, partner MOUs, field safety protocols, data tracking, and harm reduction supply logistics.

June 2026

Recruitment begins (SUD counselors, peer support specialists, MCC/field staff as applicable); initiate onboarding plan and training calendar.

July–August 2026

Hire and onboard staff; complete training (harm reduction, engagement, overdose follow-up, documentation/billing); establish referral workflow with hospitals/partners; soft-launch limited outreach days and refine.

September 2026

Scale field presence, expand partner referrals, confirm mobile routes/schedules, and ensure supply chain

and supervision coverage.
Fall 2026
Full launch of Targeted Outreach as part of ACCESS Anywhere Recovery combined team operations, with routine outreach schedule and full referral/follow-up workflow.

Mobile-field based programs

New programs
Mobile Field-Based Program

Program descriptions
The field-based program emphasizes person-centered, trauma-informed engagement strategies to build trust and support long-term recovery. Outreach staff—especially peer specialists with lived experience—serve as the primary point of contact, meeting individuals where they are physically and emotionally.
Key components include:
• Harm reduction services: Distribution of naloxone, fentanyl test strips, sterile syringes (where permitted), and safe use education to reduce overdose risk and infectious disease transmission
• Basic needs support: Provision of hygiene kits, food, water, and connections to shelter and healthcare services
• Motivational interviewing: Staff are trained in evidence-based techniques to support individuals in exploring readiness for change without judgment or coercion
• Trust building: Consistent, repeated contact in the field, prioritizing relationship development over immediate service uptake
• Rapid MAT access: Immediate referral or direct linkage to MAT providers, including same-day or next-day appointments, telehealth initiation, and transportation support

Planned funding
FSP

Planned operations
TCMHA will implement Targeted Outreach through an ACCESS Anywhere Recovery combined team model sized to meet community need. Given community size, the ACCESS Anywhere Recovery combined team will provide Mobile Clinic, Assertive Field-Based services, and Open Access as integrated components of the overall service approach.
Staffing will include SUD counselors, peer support specialists, and psychiatric prescribers. The team will deploy to high-need locations (encampments, shelters, drop-in sites, syringe service programs, and medication/mobile narcotic treatment sites) to deliver harm reduction supplies, brief interventions,

engagement, and linkage to treatment and supportive services.
A shared referral and follow-up workflow will be established with community partners (e.g., hospitals, EMS, law enforcement, schools, and other providers) to enable real-time referrals following overdose events and facilitate rapid engagement and warm handoffs.
TCMHA will maintain a structured, bidirectional referral process with community partners (e.g., hospitals/EDs, primary care clinics, syringe service programs, shelters, schools, and justice partners) to support warm handoffs into Open Access and rapid follow-up after overdose events.

Expected timeline of implementation
April–May 2026
Confirm service model, field coverage plan, coordination protocols with PD/community partners, supervision structure, and documentation/billing workflows.
June 2026
Recruitment begins for added field capacity (SUD counselors, peers, and other field staff as needed).
July–August 2026
Hire/onboard; complete training (crisis de-escalation, harm reduction, safety, documentation); begin staged expansion of field outreach days and hours.
September 2026
Operational readiness check: staffing coverage, partner referral workflows, and performance monitoring; expand to routine coverage across target areas.
Fall 2026
Full launch of expanded Mobile Field-Based operations integrated with Mobile Clinic and Open Access pathways.

Open-access clinics

New programs
Open-Access

Program descriptions
To complement field-based outreach, the City will support open-access, low-threshold clinics designed to provide rapid, flexible access to MAT without requiring appointments, extensive documentation, or abstinence.
These clinics will:
• Offer same-day, walk-in access to MAT, including buprenorphine and extended-release naltrexone
• Establish partnerships with licensed opioid treatment programs (OTPs) to provide or refer patients for methadone treatment, including transportation or mobile medication unit access where feasible
• Utilize streamlined intake processes, minimizing paperwork and eliminating unnecessary barriers such as proof of residency or insurance preauthorization

• Operate with flexible hours, including evenings and weekends, to accommodate individuals with unstable schedules
• Co-locate or coordinate with syringe services programs (SSPs) and harm reduction services to provide a comprehensive continuum of care
• Provide drop-in outpatient services, including counseling, case management, and peer support
Additionally, clinics will implement care navigation services to ensure that individuals are matched with the most appropriate form of MAT based on clinical need and personal preference. Warm handoffs, real-time scheduling, and follow-up support will promote retention in treatment.

Planned funding
FSP

Planned operations
TCMHA will implement Targeted Outreach through an ACCESS Anywhere Recovery combined team model sized to meet community need. Given community size, the ACCESS Anywhere Recovery combined team will provide Mobile Clinic, Assertive Field-Based services, and Open Access as integrated components of the overall service approach.
Staffing will include SUD counselors, peer support specialists, and psychiatric prescribers. The team will deploy to high-need locations (encampments, shelters, drop-in sites, syringe service programs, and medication/mobile narcotic treatment sites) to deliver harm reduction supplies, brief interventions, engagement, and linkage to treatment and supportive services.
A shared referral and follow-up workflow will be established with community partners (e.g., hospitals, EMS, law enforcement, schools, and other providers) to enable real-time referrals following overdose events and facilitate rapid engagement and warm handoffs.
TCMHA will maintain a structured, bidirectional referral process with community partners (e.g., hospitals/EDs, primary care clinics, syringe service programs, shelters, schools, and justice partners) to support warm handoffs into Open Access and rapid follow-up after overdose events.

Expected timeline of implementation
April–May 2026
Confirm service model, field coverage plan, coordination protocols with PD/community partners, supervision structure, and documentation/billing workflows.
June 2026
Recruitment begins for added field capacity (SUD counselors, peers, and other field staff as needed).
July–August 2026
Hire/onboard; complete training (crisis de-escalation, harm reduction, safety, documentation); begin staged expansion of field outreach days and hours.
September 2026
Operational readiness check: staffing coverage, partner referral workflows, and performance monitoring;

expand to routine coverage across target areas.
Fall 2026
Full launch of expanded Mobile Field-Based operations integrated with Mobile Clinic and Open Access pathways.

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
TCMHA will conduct an internal assessment to identify gaps between existing Medications for Addiction Treatment (MAT) capacity and the level of resources required to meet estimated population need. This assessment will include an inventory of county-operated services, Field Psychiatry capacity, contracted MAT providers, and community-based providers participating in Medi-Cal managed care and fee-for-service delivery systems. Quantitative data sources will include MAT utilization rates, wait times for medication initiation, emergency department and inpatient utilization related to substance use disorders, overdose surveillance data, and referral outcomes.

Field Psychiatry teams will contribute real-time data regarding unmet need, including the frequency of same-day MAT requests, delays in medication initiation, and barriers to access encountered in community and field-based settings. TCMHA will analyze service capacity by geography and population to identify service gaps and prioritize expansion through targeted contracting, referral agreements, and service delivery redesign. Findings will inform a phased implementation plan to ensure adequate MAT capacity and same-day access,.

Select the following practices the county will implement to ensure same day access to MAT
Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
Contract directly with MAT providers in the County

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

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
Large gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Small gap

(Permanent) Single room occupancy units
Small gap

(Interim) Single room occupancy units
Small gap

Accessory dwelling units, including junior accessory dwelling units
No gap

(Permanent) Tiny homes
Small gap

Shared housing
Small gap

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

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

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

License-exempt room and board
Small gap

Hotel and Motel stays
Medium 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
Medium gap

Short-Term Post-Hospitalization housing
Small gap

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

Peer Respite
Medium gap

Permanent rental subsidies
Large gap

Housing supportive services
Large 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 **?**
TCMHA will connect with different non-BHSA resources to expand housing. New LA County funds through Measure A will add to the development of additional supportive housing. TCMHA will work with LA's Flexible Housing Subsidy Pool to connect clients with rental subsidies and Intensive Case Management Services while building partnerships with landlords. TCMHA will also coordinate with the housing authorities for LA county and City of Pomona as a subrecipient in the CoC certificate program (pending NOFO). These efforts will be supported through data-sharing agreements and Memorandums of Understanding (MOUs) to streamline referrals and prioritize individuals who qualify for BHSA assistance.

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?
TCMHA's programs align with and enhance non-BHSA resources. TCMHA provides a structured process that connects clients to the most appropriate housing supports available. Clients who are identified as being

eligible for BHSA housing assistance will complete a housing assessment to determine needs and establish their goals while outlining a plan to address obstacles to housing such as missing personal documents or legal barriers. This approach prepares clients to successfully access external programs as they become available. TCMHA's field-based case management services help clients address housing-related issues before they escalate. Staff will provide in-home visits, landlord mediation, and problem-solving support to prevent eviction and preserve tenancy.

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

TCMHA advocates for and supports clients in securing and maintaining stable housing. Although preferred housing resources are not guaranteed, TCMHA provides high quality, person-centered housing services that lead to the most favorable and realistic outcome possible. TCMHA takes a Housing First approach and participates in the Coordinated Entry System designed by LA County. This team-based approach assists clients in locating, applying for, and securing permanent housing. Each client who is determined to be eligible for BHSA housing will receive case management that focuses on addressing existing barriers to housing, housing stability, and skill-building. Each client will complete a Housing Support Plan to outline barriers to housing, specific, measurable, achievable/attainable, relevant, and time-bound (SMART) goals, and a corresponding action plan. TCMHA participates in the Coordinated Entry System to connect client with eligible resources. Field-based supportive services will be provided to eligible housed individuals to promote housing stability and assist in promptly addressing emerging issues.

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)?

TCMHA has partnered with six housing developers to provide permanent supportive housing (PSH) units, allowing direct referrals for BHSA-eligible individuals. On-site supportive services are provided to tenants in these units, and additional tenants can access assistance with connecting to community resources, including enrollment in mental health services. TCMHA also owns a property that was converted into an 8-unit, low-barrier housing option, designed to accommodate individuals with housing vouchers or subsidies. Through these combined efforts, BHSA-eligible individuals have access to PSH while receiving the wraparound support necessary to maintain stability and enhance long-term housing retention. TCMHA's connection to the Coordinated Entry system ensures that clients have access to additional PSH resources throughout the County.

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

TCMHA will integrate on-site and field-based services to ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care. After developing standardized processes upon finalizing Memoranda of Understanding (MOUs), Residential Services Coordinators (RSCs) and housing staff collaborate with property management, treatment teams, and community partners to connect tenants with mental health services, substance use support, and other resources. Clinical staff conduct assessments, develop individualized service plans, and coordinate care for tenants in both permanent supportive housing and other housing settings. Field-based services, including in-home visits and problem-solving support, ensure that clients facing housing-related challenges, such as risk of eviction, receive timely interventions and linkage to appropriate services. By embedding these supports and maintaining active communication, the system ensures that all residents have consistent access to the behavioral health care and housing services needed to maintain stability and well-being.

Eligible Populations

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

TCMHA identifies, screens, and refers individuals eligible for BHSA Housing Interventions through a coordinated, multi-step process. Community members can connect to TCMHA by contacting the Access to Care team or through a referral from another agency. Intake staff first conduct an assessment to confirm they meet criteria for mental health services. Clinical staff identify clients with housing-related needs during routine assessments or treatment interactions. Housing staff then conduct individualized housing assessments to determine eligibility and appropriate housing goals, such as obtaining housing, maintaining current housing, or preventing eviction. Housing staff complete a Housing Support Plan which is shared with the rest of the client care team to guide next steps and to connect clients to suitable housing resources, including permanent supportive housing units, vouchers, or other low-barrier options. Housing staff will confirm that the client is connected to the Los Angeles Coordinated Entry System, or they will open them in the system, to ensure the client is able to be matched to county-wide resources.

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
TCMHA reviewed data, behavioral health clinical records, and the Homeless Management Information System (HMIS) information to assess trends in housing instability and service utilization.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
TCMHA analyzed research regarding affirming housing interventions.

In the child welfare system
Stakeholder engagement included engagement of school officials and child services and transition age youth organizations and community members.

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
TCMHA also analyzed demographic data to identify disparities among subpopulations, including veterans, older adults, and individuals with disabilities, ensuring housing programs are equitable, person-centered, and recovery-oriented.

In, or are at risk of being in, the justice system
TCMHA engaged the police departments for the three cities to participate in conversations during our stakeholder meetings as well as a smaller focus group

In underserved communities
TCMHA invited all community members and a variety of organizations to our stakeholder meetings as well as focus groups targeting the following populations: African American, Asian American/Pacific Islander, Hispanic, law enforcement, first Responders, and Healthcare Professionals. LGBTQ+, Native/Indigenous Americans, Older Adults, Peers, Clients/Caregivers/Community Members, People Experiencing Homelessness or who are at risk, people with disabilities, people with substance use disorders, school officials/child services, and transition age youth. Among those were Pomona's African American advisory Alliance, Kennedy Austin Foundation, the Asian American Studies Department at Pomona College, Galan Cultural Center, Pomona Valley Pride, Costanoan Rumsen Tribe, Hope for Home homeless shelter, Service Center for Independent Life, and Just Us 4 Youth.

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?

TCMHA will coordinate closely with the local Continuum of Care (CoC) through a structured referral and communication process to ensure timely access to Housing Intervention services for individuals with behavioral health needs. Coordination will occur through regular case conferencing, shared data systems, and established referral protocols between behavioral health providers and CoC partners.

Behavioral health staff will work directly with CES navigators to identify eligible clients, complete necessary assessments, and ensure that referrals include comprehensive information regarding behavioral health status, service needs, and ongoing supports.

TCMHA will designate a Housing Liaison to serve as the primary point of contact with the CoC. This liaison will participate in CoC meetings, maintain communication with housing providers, and facilitate bi-directional referrals. When clients are enrolled in behavioral health programs, staff will support their engagement in housing services by coordinating care plans, attending case management meetings, and ensuring continuity of behavioral health treatment during transitions into housing.

Additionally, data sharing agreements between TCMHA and the CoC's Homeless Management Information System (HMIS) will support tracking of referrals, placements, and outcomes, enabling both systems to monitor progress and identify service gaps.

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

TCMHA will collaborate with local CoCs through integration of the coordinated entry system, braided funding, and participating in collaborative meetings to identify successes and areas for improvement.

Public Housing Agency

TCMHA is actively engaged with the local housing authorities including Pomona and LA County. TCMHA has access to the county HMIS database and partners with the CoCs as sub-recipients of CoC certificates.

TCMHA will work with the housing authorities to collaborate on local plans and align resources.

MCPs
TCMHA and the local MCPs will collaborate to outline the resources available through each agency and implement a system to communicate regarding joint participants. TCMHA will confirm BHSA eligibility and resources available while the MCPs will confirm insurance eligibility and availability of funding through their CalAIM Community Supports.

ECM and Community Supports Providers
TCMHA will build a partnership with the ECM and Community Supports providers to align goals, share data, and conduct case conferencing for joint clients. Both will identify when there is a need to refer to each other's services when a community member is only connected to one partner. TCMHA will provide updates on eligible resources available for clients, and ECM and Community Support providers will identify when they have exhausted funds for each client.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
TCMHA will build connections with other programs such as CalWORKS/TANF housing programs, child welfare housing programs, and PSH developers and when appropriate, implement an MOU to streamline communication. TCMHA will seek out partners to identify a unified goal of supporting BHSA eligible community members with housing needs. By building a cross-system approach that leverages housing, social services, and behavioral health resources, this collaboration will help prevent homelessness, promote stability, and increase sustainable recovery.

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?
TCMHA will provide on-site supportive services at partnered PSH properties and case management for individuals and families, with CoC certificates, living in scattered-site housing. TCMHA's care teams will work directly at these locations to support client recovery as well as connect them to healthcare, employment, education, and other community resources, while collaborating with property management to promote housing stability and prevent eviction. TCMHA will be available to offer support to Homekey+ projects by providing coordinated services, case management, and referrals for BHSA-eligible individuals, ensuring stable housing and improved health outcomes.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

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

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

Is the county providing this intervention?
Yes

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

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
114

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
88

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

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
TCMHA estimated total rental subsidies using Fair Market Rent (FMR) and number of clients in need of assistance from historical client trends. Using data we identified the distribution of household size needs. Total rental subsidies were identified by unit size and incorporated annual rent, security deposit, and utility allowance comparable to the schedule used by the Los Angeles County Development Authority. Interim housing subsidies were estimated based on local bed rates for the maximum allowable time frames.

For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

TCMHA will provide rental subsidy assistance to qualifying clients for a duration based on individual need and, to the extent possible. TCMHA will work with local landlords to identify units that fall at or below Fair Market Rents, are open to partnering with the agency, and will accept the rental subsidy directly from the agency.

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

TCMHA will leverage its strong partnerships with local organizations, housing authorities, and state and local agencies to identify and maintain a portfolio of available housing units for BHSA-eligible individuals. This will include close collaboration with county partners such as the Continuum of Care (CoC), local public housing authorities, and community-based housing providers to ensure access to a range of housing options, including permanent supportive housing and units secured through master leasing.
Through coordinated data sharing and regular case conferencing, TCMHA will track housing availability, assess client needs, and match eligible individuals to appropriate placements in real time. In partnership with local developers, non-profit housing agencies, and county housing departments, TCMHA will work to expand and sustain the housing portfolio, leveraging both existing resources and new development opportunities.
These collaborative efforts will ensure a responsive, integrated system that supports timely placement of BHSA participants into safe, stable, and recovery-oriented housing environments.

Total number of units funded with BHSA Housing Interventions per year

135

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

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
47

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
TCMHA will use BHSA Housing Interventions to maintain ongoing operations at current property that provides stable housing for 8 separate households along with 3 new projects that will add 39 additional units. These funds will support core housing-related expenses necessary to sustain the property's operations and continued occupancy for residents. TCMHA contracts with a local property management company to oversee day-to-day operations, including collecting rent, property maintenance, coordination of unit turnover, inspections, and compliance with applicable housing standards.

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

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
47

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

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
88

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Funds will be used to engage landlords and provide education and ongoing support through monthly meetings and special trainings geared at landlord-identified areas of concern. Funds will also be available for financial mitigation, such as holding fees, covering unit repairs, rental losses, or damages, to reduce barriers to tenancy. Workshops geared to address tenant and landlord rights and responsibilities will be available to present at properties throughout the three cities or in a local community hub that is accessible to local landlords and their tenants.

Total number of units funded with BHSA Housing Interventions per year
88

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

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
41

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Funds may cover essential costs such as security deposits, rental application fees, move-in expenses, storage fees or rent/utility arrears. Integrated with TCMHA's established housing referral and supportive service framework, this intervention allows staff to quickly address financial barriers that normally present delays in completing applications, getting a client approved at a property, or moving in, provided they have exhausted Medi-Cal assistance first.

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

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

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

80

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

TCMHA will provide housing transition navigation and tenancy-sustaining services to individuals who are determined to be ineligible for these supports through their MCP. Using BHSA Housing Interventions funding, TCMHA staff will assist clients with locating and securing housing, completing applications, and coordinating move-in logistics. Ongoing tenancy-sustaining services will include landlord engagement, eviction prevention, and linkage to clinical and community supports to maintain housing stability. Field-based staff will provide direct, personalized support to address barriers to successful tenancy. BHSA funds may also cover short-term assistance such as application fees, deposits, or basic household needs necessary for successful housing retention.

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
350

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
TCMHA will use BHSA Housing Interventions funding to support outreach and engagement through its Forensic Assertive Community Treatment (FACT) and Assertive Community Treatment (ACT) Full Service Partnership (FSP) teams. Each team will be comprised of specialized staff: psychologist, clinician, peer support specialist, behavioral health support staff, and a dedicated housing specialist. They will actively engage unhoused or at-risk community members to build trust, assess needs, and connect them to behavioral health and housing services. The same team will provide continuity of care, supporting clients through enrollment, housing navigation, and ongoing tenancy support. BHSA funds will be used for staff outreach activities, engagement supplies, transportation, and flexible resources that reduce barriers to accessing and maintaining housing.

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

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

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

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
2

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
City of Pomona Tiny Homes Project

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
37

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
16

Total number of units funded with Housing Interventions funds only
12

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
9/1/2026

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
278478

Have you utilized the "by right" provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
Under the BHSA Integrated Plan, housing support staff will be funded through Housing funds and will serve Children, Transitional Age Youth (TAY), adult and older adult populations. Hosing program intends to increase access to permanent supportive housing for people meeting BHSA eligibility who are chronically homeless, experiencing homelessness, or are at risk of homelessness. These housing staff represent 63% of

the housing team and will provide comprehensive housing support services, including system navigation, tenant services, housing stabilization, and linkage to community resources.
Core services will include supporting individuals who are homeless, at risk of homelessness or chronically homeless with assistance with housing applications and documentation, landlord engagement and advocacy, coordination with property management, support with lease compliance, crisis intervention related to housing retention, benefits linkage, and referrals to behavioral health, employment, and social services. Staff will work to promote long-term housing stability and self-sufficiency through individualized service planning and ongoing supportive engagement.
In addition, Residential Coordinators who support as landlord liaisons, represent 37% of staff and will provide direct supportive services to individuals residing in program-supported housing. These services may include skills related to maintaining housing, conflict resolution, community integration activities, independent, and coordination of care with behavioral health providers and other service partners. Residential Coordinators play a key role in maintaining a safe, supportive, and recovery-oriented living environment.

Is the county providing this intervention to chronically homeless individuals?
Anticipated number of individuals served per year
000

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)
n/a

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
Undecided

Housing Deposits
Undecided

Housing Tenancy and Sustaining Services
Undecided

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Undecided

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)?**
Clinical and housing staff will assess client needs during intake and ongoing treatment planning to confirm Medi-Cal eligibility and appropriateness for MCP-covered housing services such as Housing Transition Navigation or Tenancy Sustaining Services. Once confirmed, TCMHA's Housing Division will coordinate directly with MCP partners to complete and submit referrals, ensuring warm handoffs and continuity of care. Clients ineligible for MCP-covered supports will be connected to BHSA-funded housing interventions for comparable assistance, maintaining equitable access to housing stability resources.

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

TCMHA will collaborate closely with LACDMH and local MCPs to ensure that the county's behavioral health contracted provider network for Housing Interventions is known, updated, and accessible. TCMHA will provide MCPs with up-to-date contact information, service descriptions, and referral pathways for housing-related behavioral health supports. Additional coordination will occur through regular cross-system meetings, data-sharing agreements, and participation in county-level housing and care coordination workgroups.

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

We are in the process of developing formal workflows and Memorandums of Understanding (MOUs) to strengthen coordination and align network development between TCMHA and the MCPs. We are focused on establishing standardized referral pathways, data-sharing protocols, and regular cross-system meetings to support collaboration between use.

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?

Members of the client's care team will maintain active oversight of the client's housing status and contact the MCPs for regular updates on service utilization. When MCP-covered housing supports reach their limits, the client's treatment team will assess ongoing needs and client's access to BHSA Housing Interventions funding to maintain housing stability and prevent service gaps. Care transitions are supported by joint planning meetings between treatment teams, MCP representatives, and county housing partners, ensuring timely communication, shared care plans, and ongoing engagement.

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
n/a

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?
Yes

Program

What Behavioral Health Services Act (BHSA) component will fund the innovative program?

Behavioral Health Services and Supports

Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

The Psychiatric Advanced Directives (PADs) project will test a peer-driven, multi-county model using standardized templates and a secure, cloud-based platform to enhance mental health crisis care. Through stakeholder collaboration, this project will evaluate how PADs promote client autonomy and improve crisis response, ultimately establishing statewide best practices for consumer-directed care.

Please describe intended outcomes of the project

Enhanced Individual Autonomy: PADs promote self-determination by allowing individuals to guide their own treatment during times of mental health crises.
Reduction of Involuntary Care: Properly implemented PADs can reduce the use of involuntary hospitalizations and emergency holds (5150 applications).
Improved Crisis Management: By detailing preferred medications and treatments, PADs help first responders and clinicians make faster, more effective decisions, which can lead to shorter hospital stays.
Better Communication and Trust: PADs strengthen communication between patients and providers, which can increase medication adherence and boost trust in the behavioral health system.
Support for Family/Advocates: PADs provide a mechanism for designated agents to advocate for a person's wishes, enhancing family/advocate involvement in the care process.

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

---

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

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

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

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

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

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

Build Workforce to Address Statewide Behavioral Health Goals

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

---

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
19

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

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Psychiatric Technician (PT)
Licensed Clinical Social Worker
Psychiatrist
Other qualified provider
Licensed Marriage and Family Therapist

Please describe any other key workforce gaps in the county
Several key workforce gaps have been identified. Tri-City continues to experience challenges recruiting and retaining staff in high-acuity behavioral health services, particularly in crisis response, adult FSP programs, and medication support. These roles often require specialized licensure and involve demanding working

conditions, which may contribute to ongoing vacancies.

Tri-City is also experiencing challenges in developing and recruiting clinical supervisors. Compensation for supervisory roles does not always keep pace with the financial burden of advanced clinical education, including student loan debt. In addition, supervisory roles carry increased administrative, clinical, and liability responsibilities, which may not be proportionately incentivized.

These challenges are further compounded by regulatory and licensing requirements related to supervision, including required supervision ratios, documentation standards, and time commitments. These requirements can limit the availability of qualified supervisors and reduce overall system capacity to support and advance clinical staff.

Broader workforce pipeline challenges also contribute to staffing gaps. Academic and training programs do not always adequately prepare students for work in public behavioral health settings, particularly in areas such as crisis intervention, community-based care, and working with high-acuity populations. This can result in a mismatch between new graduates' expectations and the realities of public sector behavioral health work.

Additionally, overall compensation for behavioral health professionals often lags behind comparable roles in the broader healthcare system, including medical and allied health positions. This disparity can make recruitment and retention more difficult, particularly for licensed and specialized roles, and may contribute to workforce migration to higher-paying sectors.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Over the next three fiscal years, the county expects workforce needs to shift toward expansion of multidisciplinary, community-based behavioral health teams needed to implement new and expanded evidence-based practices under Behavioral Health Transformation and BH-CONNECT. This will likely increase demand for licensed clinicians, psychiatric prescribers, peer support specialists, employment specialists, community health workers, care coordinators, and clinical supervisors, as well as staff with experience in fidelity-based implementation and quality oversight. In addition, there are new professions introduced such as Nurse(s) and Occupational Therapist(s) that traditionally have not been a part of the Tri-City workforce. Tri-City also anticipates greater need for training, supervision, and retention strategies to support ACT, FACT, Coordinated Specialty Care, IPS Supported Employment, and other emerging practice requirements. As these reforms are implemented, workforce needs are expected to become more specialized, team-based, and community-focused, with particular pressure in high-acuity and field-based service settings.

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
Tri-City plans to share information about the scholarship program with staff and local colleges to encourage applications.

The initiative aims to:

Address behavioral health workforce shortages

Improve access to culturally responsive care

Promote long-term staff retention and professional development

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
Tri-City has actively promoted the student loan repayment program by disseminating information to staff and encouraging eligible individuals to submit applications. Tri-City intends to integrate the student loan repayment program into a comprehensive workforce development strategy aimed at:

Mitigating behavioral health workforce shortages

Enhancing access to culturally responsive care

Supporting long-term staff retention and professional growth

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
Tri-City plans to apply for funding through the Behavioral Health Recruitment and Retention Program. Tri-City plans to utilize these funds to expand outreach efforts, strengthen partnerships with graduate programs, and help with offsetting vacancy-related recruitment impacts and reduce turnover.

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

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

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
We plan to expand our internship program into a comprehensive, agency-wide initiative by building partnerships with additional universities and providing enhanced comprehensive support.

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 3rd Submission May 2026.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)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment
4/3/2026

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

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

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 May 2026.pdf
Behavioral Health Director Certification. Additional Text.pdf
Behavioral Health Director Certification Template for OP 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.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*"