SAN JOAQUIN COUNTY

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BEHAVIORAL HEALTH SERVICES ACT (BHSA) THREE-YEAR INTEGRATED PLAN

JULY 1, 2026

SAN JOAQUIN COUNTY | 2026

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San Joaquin County

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

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
San Joaquin County

Behavioral Health Agency Name
San Joaquin County Behavioral Health Services

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County Behavioral Health System Overview

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	5492
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	0
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	94
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	70

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	34
Were chronically homeless or experiencing homelessness or at risk of homelessness	24
Were in the juvenile justice system	366
Have reentered the community from a youth correctional facility	345
Were served by the Mental Health Plan and had an open child welfare case	887
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	<11*

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	130

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	1633
Received Medi-Cal SMHS	18664
Received DMC or DMC-ODS services	5271
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1304
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	000

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	000
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	000
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)	1696
Were incarcerated (including state prison and jail)	000
Reentered the community from state prison or county jail	000
Received acute psychiatric services	629

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

Admitted or detained for 72-hour evaluation and treatment rate

1215

Admitted for 14-day and 30-day periods of intensive treatment
427

Admitted for 180-day post certification intensive treatment
<11*

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

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
32

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

Please explain
Those that are marked with "000" were not tracked for fiscal year 2024-2025. BHS began the process of tracking these numbers this FY 2025-26 through a Client Assessment Tool. These sections can be provided in the next Annual Update to the Integrated Plan.

Please describe the local data used during the planning process
Utilization Analysis of existing systemwide programs, Statewide Behavioral Health Goals Data, Evaluation of Prevention and Early Intervention Programs

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.
San Joaquin County BHS Inspire CARE Act program provides FSP services to all CARE participants from a multidisciplinary team of BHS staff. This includes clinicians, case managers, behavioral health outreach

workers/certified peer support specialists in addition to psychiatry. Services include case management, therapy if indicated, assessments, linkage to community resources, SUD treatment if indicated, housing referrals and medication management. Participants are assisted with transportation to appointments and court hearings if needed and staff work collaboratively with petitioners, with proper releases, to ensure comprehensive care. Referrals are made to the BHS Housing for Health division to secure housing placements in a continuum of housing resources including emergency shelters, motels, sober living environments, transitional and permanent housing. Priority is given to CARE participants for housing placements.

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

BHS CARE program has developed a CARE referral form and dedicated email in order to accept and review referrals received from internal BHS programs. These referrals are reviewed with the referring program and potential CARE petition is discussed. If a CARE petition is appropriate, the BHS CARE Manager will complete the petition. If the individual does not appear to meet the CARE criteria, referral to the appropriate BHS program, most suited to address the participant's needs is completed.

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.

If a referral is received and a petition for CARE is not appropriate, the BHS CARE Manager collaborates with the referring program to assess the participant's needs. The BHS Inspire FSP program is often the appropriate program for the participant as the Inspire FSP program is designed to provide FSP services to members who frequently utilize crisis or hospitalization services, who may have a co-occurring disorder, who are needing services to reduce deterioration or decompensation, who often have a history of justice involvement and who are often reluctant to consistently engage in behavioral health services. Since this is also a BHS program and currently served by the same BHS staff who provide the CARE services, the Inspire FSP participants receive comparable services to those enrolled in the CARE program. Upon determining that the Inspire FSP program or another BHS program is the best option for the participant, a warm handoff is conducted to transition the participant to the appropriate program, ensuring that enrollment documents are completed as well as referral and initial evaluation with the program's psychiatrist is completed. All of these services are documented in the BHS health record.

County Behavioral Health Technical Infrastructure

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

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

Please select which of the following EHRs the county uses
SmartCare
Netsmart

County participates in a Qualified Health Information Organization (QHIO)?
No

Application Programming Interface Information

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

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://fhir-calmhsa-provider.ehn-prod.net/fhir/swagger-ui/?page=Location

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

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

County Behavioral Health System Service Delivery Landscape

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

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

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

Please select all services the county behavioral health system plans to provide under the PATH grant
Supportive and Supervisory Services in Residential Settings

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

Community Mental Health Services Block Grant (MHBG)

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

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Discretionary/Base Allocation

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

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

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

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

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

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
No

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

Bronzan-McCorquodale Act

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

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

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

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

Public Safety Realignment (2011 Realignment)

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

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

Medi-Cal Specialty Mental Health Services (SMHS)

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

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

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

Peer Support Services
IPS Supported Employment
FACT
CSC for FEP
ACT

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

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

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

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Inpatient Services (ASAM Levels 3.7 & 4.0)
Peer Support Services

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

Other Programs and Services

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

Program or service

Care Transitions

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

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

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

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

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

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

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

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

Mark page as complete

Priority statewide behavioral health goals for improvement

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

Access to care: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Same

For children/youth
Below

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

For children/youth
Above

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

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?
Age
Race or Ethnicity

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Primary Measure: SMHS Adult Penetration Rates:
County and Statewide penetration rates were very similar, (3.6). County rates were lower for both older (1.4/1.3) and younger adults (3..8/3.9) , and, most notably, lower than Statewide rates for younger adults (21-32), (3.4/3.6). Rates were lower for females (3.3).
Rates were lower among Hispanics (2.5) and Asian Pacific Islanders (2.3), and County rates for Blacks were lower than Statewide rates for Blacks (5.4/7.1).
Rates were lower among Spanish-speakers (.9), and County rates were lower than statewide for Spanish-speaker rates as well (.9/1.1).

Primary Measure: SMHS Youth Penetration Rates:
San Joaquin County youth penetration rates were among the lowest in the State (2.4/4.2). Rates for children 0 to 11 (.5/.9/1.9) were lower than for older children (4.2) and adolescents (3.2). Male rates were lower than female rates (2.1/2.7). Penetration rates for Hispanics and Spanish speaking youth were low (2.3/1.6) but were even lower for Asian Pacific Islanders (.9).

Primary Measure: NSMHS Adult Penetration Rates:
Overall adult NSMHS penetration rates were among the highest in the State. Older adults (69+) (15.5) and younger adults (21-32) (17.1) had lower penetration rates than average. Male adults had lower penetration rates (14.6). Asian Pacific Islanders (15.3) and Blacks (17.1) had lower penetration rates.
(Since there were no overall County rates available, we compared the unweighted average rate within each demographic group).

Primary Measure: NSMHS Youth Penetration Rates:
San Joaquin's overall penetration rate for Non-Specialty Mental Health Services was higher than the state average. Children between ages 3-5 (10.5) had lower penetration rates. Females (15.8) had slightly lower penetration rates. Blacks (13.9) and Asian Pacific Islanders (12.1) had lower penetration rates.
(Since there were no overall County rates available, we compared the unweighted average rate within each demographic group).

Primary Measure: DMC-ODS Youth and Adult Penetration Rates:
San Joaquin penetration rates were lower than the Statewide average but were nearly the same in FY 2023-24.
Like the State overall, San Joaquin's youth (.3) and older adults (.5) had lower penetration rates than the County overall, but San Joaquin youth .3/1.0) had lower rates than the Statewide average. Hispanics (.6) had a lower penetration rate than the overall County rate (.9), but rates were consistent with Statewide data for these populations.

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
The county will focus on our Adult Penetration Rates for SMHS, and disparities related to access to care by

increasing our outreach and engagement efforts via the BHSA Outreach Team. The BHSA outreach team has been integral in the past year for focusing within the community to provide MH and SUD services information to educate the community, most specifically our underserved communities such as Hispanics, Asian Pacific Islanders and Black communities. The BHSA team will continue to promote BHS services throughout the county for this.

The Adult System of Care PEARLS program provides in-home support to Older Adults experiencing minor depression to assist in improving quality of life. PEARLS provides outreach to the Older Adult community aimed to assist in addressing isolation and preventing exacerbation of minor depression symptoms. Adult System of Care is currently in the RFP process to establish a Day Treatment Intensive and Day Rehab program to serve as a preventative measure to hospitalization or for those stepping down from hospitalization. Evidence Based Practice using the ACT model will be provided by a contractor to assist adults needing a high level of services in the community setting. Whole Person Care team provides outreach and engagement for San Joaquin County. The goal of this team is to link individuals who are un-sheltered homeless or sheltered homeless to services to support goals of recovery. Individuals are linked to behavioral health services, substance use services, co-occurring services, managed care plan, or housing support. All staff are trained in cultural competence. We provide services in several languages or utilize the language line when needed.

The SMHS Youth Penetration Rates will be addressed by the CYS CARES team. This team will work with the community to educate, promote, and provide information on SMHS for the children system of care. Like the BHSA outreach team, the Cares team will partner and work with underserved communities where disparities exist. In addition, Children & Youth Services (CYS) has drafted a Request for Proposal for BHSA funded early childhood services. Components of the program are targeted to address age ranges 0-7 including: PCIT, infant and early childhood consultation, as well as outreach and engagement to the community. This will be released on or around 7/1. Additionally, we will be collaborating with one of our community providers that will be launching a program targeting the 0-5 population to ensure that there is ongoing communication around appropriate linkages to SJCBHS. We meet with our contractors quarterly to evaluate progress and barriers.
This past year we launched an acculturation tool aimed at gathering data regarding acculturation concerns. Starting July 1, we will convene meetings to synthesize, analyze and interpret data collected to determine how to best incorporate in to service delivery and program design.

The county plans to strengthen community outreach by partnering with schools, community organizations, faith-based groups, and primary care providers. Special emphasis will be placed on culturally responsive outreach to Hispanic/Latino communities, including Spanish language materials and bilingual staff. Outreach teams will also prioritize youth serving systems to better engage younger populations. Public education campaigns will continue to be launched to increase awareness of available services and reduce stigma with seeking care.

To improve access to care, the focus will be on reducing barriers to care, in which the county will expand service delivery options, including telehealth, community-based services, collocate services. Implement flexible scheduling, increase transportation services and assistance, streamline intake processes.

The county will regularly analyze penetration rate data by age, ethnicity, and region to identify gaps and track progress. Continuous quality improvement processes will be used to refine outreach and service delivery strategies.

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)
BHSA Full Services Partnership (FSP)

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?
Age
Race or Ethnicity

Homelessness: Supplemental Measures

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

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?
Below

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?
No Disparities Data Available

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

Primary: Point in Time (PIT) Count of People Experiencing Homelessness (Per 10,000 residents):
Those between age 35-44 were most likely to be homeless, followed by adults over the age of 45. Males were significantly more likely to be homeless in San Joaquin County. American Indian/Alaskan Natives were more than 7 times as likely to be homeless than the overall County population. Blacks and Native Hawaiians/Pacific Islanders were more than twice as likely to be homeless than the County average.

Primary: Percent of K-12 Public School Students Experiencing Homelessness, 2023-24:
San Joaquin County's Public-School students were less likely to be homeless than the Statewide average. African American students were almost twice as likely to be homeless. Hispanic, American Indians and Pacific Islanders as well as multi-race students were more likely to be homeless. Migrant children were almost three times as likely to be homeless.
English Learners were more likely to be homeless. First through fourth grade students were slightly more likely to be homeless (>4%) but 12th graders were most likely (5.1%).

Secondary: People who Accessed Homeless Services from a Continuum of Care, 2023-24:
San Joaquin County residents were more likely to access services from the the regional Continuum of Care (CoC) than residents of other counties. 112 per 100,000 San Joaquin County residents accessed CoC services vs 91 Statewide. Asian Americans were least likely among race/ethnicity groups to access CoC services Persons over the age of 65 were least likely to access CoC services.

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)

The county is proud to have a developed a new division for BHS for the sole purpose of housing interventions for members needing housing services. The newly formed, Housing for Health division, with a new deputy director, will lead efforts in strengthening the access to housing for those that are homeless at

risk of homelessness across our system of care, including SUD members. The Housing for Health division will focus on strengthening the housing continuum by expanding transitional/interim housing options for members who are homeless. The goal is to leverage Behavioral Health Bridge House grant, Transitional Rent benefit, and BHSA housing intervention dollars to create a braided funding stream so there is limited disruption to the member's housing. In addition, the Housing for Health provides case management support to all members in housing which is trauma informed and culturally competent. Understanding the unique challenges of our members and using culture as a driving point in treatment, our goal is to support the member with getting linked to permanent supportive housing.

File Upload

Please identify the category or categories of funding that the county is using to address the homelessness goal
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
Not Applicable

For children/youth
Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000
Below

30-day involuntary detention rates per 10,000
Below

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
Below

Permanent Conservatorships
Below

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

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

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

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Above

For children/youth
Above

Crisis Stabilization

For adults/older adults
Above

For children/youth
Above

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

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
Primary Measure: Inpatient Administrative Days:
San Joaquin County data not available
Statewide: Adults ages 57-68 (33.4) had higher rates among adults. Youth age 18-20 (11.0) had the highest rates among children. Asian Pacific Islander adults (29)had higher rates than other races/ethnicities. Male adults (24.5) and children (10.5) had higher rates.

Supplemental: SMHS Crisis Service Utilization - Crisis Residential Tx Services:
Service utilization was higher (25.6) in San Joaquin County than Statewide (22.8). San Joaquin children received more than 10 days more service than children Statewide (31.9/21.6). Adults, age 57-68 (43.4), adult males (43.4) and adult Hispanics (41.7) had higher rates within the county and across the State. Spanish-speaking adults in San Joaquin received more crisis residential treatment than their Statewide counterparts (34.3/18.3)

Supplemental: SMHS Crisis Service Utilization - Crisis Intervention:
Crisis intervention service utilization was lower in San Joaquin County than Statewide (223/240). Adults ages 33-44 (236), males (221) and African Americans (222) had higher rates within the county among adults. African American (252) and White (252) had higher rates within the county among children.
Children ages 6-11 (290) had the highest rates within the County and higher than within the age category Statewide (284).

Supplemental: SMHS Crisis Service Utilization - Crisis Stabilization:
Both child (21.6/18.6) and adult (28.6/24) crisis service utilization was higher within the County than Statewide. Among adults, utilization within the County and compared to the State were highest for those ages 33-44 (32.4/26.1), for Whites (30.1/24.9) and Spanish-speakers (34.3/18.4). Among children, utilization within the County and compared to the State were highest for those age 12-17 (27.1/19.9) and for Hispanics

(30/18)

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)
None at this time

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)
Beginning July 1, 2026, San Joaquin County Behavioral Health Services (BHS) 24-Hour Services will implement targeted system enhancements designed to reduce institutionalization and improve crisis response outcomes across the lifespan. These initiatives are informed by local utilization data indicating that crisis stabilization service utilization rates exceed statewide averages for both adults and youth. Data analysis demonstrates disproportionately higher utilization among adults ages 33–44, individuals identifying as White, Spanish-speaking populations, youth ages 12–17, and Hispanic youth.
To address these trends, the County will strengthen the continuum of crisis care through expansion of community-based alternatives to inpatient hospitalization and enhanced early intervention strategies.

Key initiatives include:

Mobile Crisis and Community-Based Stabilization Services
The County will enhance mobile crisis response referrals to provide earlier intervention in community settings, particularly targeting populations demonstrating higher crisis utilization. This includes strengthening partnerships with law enforcement, emergency medical services, schools, and community-based organizations to improve diversion from emergency departments and inpatient psychiatric settings. Culturally and linguistically responsive services will be prioritized to address disparities among Spanish-speaking and Hispanic populations.

Development of Youth-Focused Crisis Diversion Strategies

Given higher crisis utilization among youth ages 12–17, the County will expand youth-specific crisis stabilization and step-down services. Planned initiatives include enhanced collaboration with school districts, family resource centers, and children's system partners to provide earlier behavioral health engagement, wraparound supports, and family-centered crisis intervention. These efforts aim to reduce the likelihood of institutional placement by strengthening community-based supports.

Strengthening Crisis Stabilization Through the BeWell Campus Continuum
The County is continuing development of an integrated crisis continuum through the BeWell Campus model, which will include crisis stabilization, psychiatric health facility services, sobering services, and urgent care-level behavioral health response. This integrated model is designed to reduce fragmentation, improve care transitions, and decrease reliance on inpatient institutional care.
Targeted Adult Diversion and Step-Down Services
For adults, who demonstrate elevated crisis utilization locally, the County will expand access to step-down services, including enhanced discharge coordination, peer support services, and short-term intensive outpatient stabilization supports. Partnerships with housing providers and community-based organizations will also be strengthened to address social determinants contributing to repeated crisis utilization.

Cultural and Linguistic Responsiveness Enhancements
Recognizing higher utilization among Spanish-speaking individuals and Hispanic youth, the County will continue to expand bilingual staffing, culturally responsive service models, and partnerships with trusted community providers. These strategies aim to improve engagement, reduce crisis escalation, and promote recovery in community settings.

Data-Driven System Improvement
The County will continue to use local crisis utilization, demographic, and outcome data to guide program planning and resource allocation. Ongoing monitoring of crisis service trends will inform quality improvement efforts and ensure that interventions are responsive to populations experiencing poorer outcomes relative to statewide benchmarks.
Through these coordinated initiatives, San Joaquin County aims to strengthen the crisis continuum, improve equity in access and outcomes, and reduce unnecessary institutionalization by enhancing timely, community-based behavioral health care.

SJCBHS will be adopting a new EHR system where inputting cultural data will be required to support adjustment across behavioral health systems for support.
Along with the new EHR system, referral processes to other resources within our community with our contractors will be streamlined, reducing gaps in linking to stabilizing or higher level of care services.
To add to our current system, SJC BHS CYS Crisis team that conducts follow-ups for youth who had a crisis visit or are discharged from a hospital, will introduce services they may qualify for including DTI, DR, and TBS . The interest of the youth and/or family will be documented, then followed up on during the intake and assessment process so that services can be expedited at this initial visit.

Given higher crisis utilization among youth ages 12–17, the County will expand youth-specific crisis stabilization and step-down services. Planned initiatives include enhanced collaboration with school districts, family resource centers, and children's system partners to provide earlier behavioral health engagement, wraparound supports, and family-centered crisis intervention. These efforts aim to reduce the likelihood of institutional placement by strengthening community-based supports.
Also, CYS recently identified a provider for Day Treatment Intensive and Day Rehab. These are Medi-Cal funded structured, multi-disciplinary programs that are intended to be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting. As the contractor hires staff, onboards, and trains we expect to make these services available for those that meet criteria. CYS will be meeting monthly with the contractor to monitor referrals.

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

Justice-Involvement: Primary Measures

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

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

For adults/older adults
Below

For juveniles
Above

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

What disparities did you identify across demographic groups or special populations?
Sex
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
Primary Measure: Adult and Juvenile Arrest Rate (per 100,000):
San Joaquin's per 100,000 arrest count was lower than the Statewide average in both 2023 and 2024. Adult and juvenile males had higher arrest rates. Adults between the age of 18 – 39 had higher arrest rates. African Americans had higher arrest rates than White or Hispanics

Supplemental: Three-Year Recidivism Rate, Adults:

San Joaquin County's three-year recidivism rate was nearly ten percentage points higher than the Statewide average. Males had higher recidivism rates Transitional Age Youth between the ages of 20-24 had the highest documented recidivism rates—over 10 percentage points higher than any other age group. However, Statewide data indicates that youth ages. 18-19 were likely to have had even higher recidivism rates. White/Caucasians had the highest recidivism rates among race/ethnicity groups.

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)

The county will continue to increase access for those that are justice involved through several programs of our Justice and Community Integration Division (JCID). This division has multiple programs funded through BHSA including the Inspire FSP program, Misdemeanor Incompetent to Stand (MIST) program, Care Court, Intensive Justice FSP program, Community Corrections FSP, JCID Restart Program, and the newly developed Felony Incompetent to Stand (FIST) program.

JCID has launched or is in the process our launching several new programs in hopes to divert people with behavioral health disorders away from incarceration and to reduce recidivism rates. These new programs include:

Jail BH Re-Entry
Jail re-entry services are provided to incarcerated persons to connect clients needing behavioral health services to community-based care prior to their release, and to establish a plan for their on-going treatment needs and to ensure successful warm handoffs to receiving behavioral health treatment program and/or community based organization.

Inspire FSP for Care Act Participants
The Inspire program serves individuals between the ages of 18-59 who are hesitant or resistant to engaging in mental health treatment and/or those that have been petitioned into Care Court. InSPIRE strives to find additional pathways to mental health services for hesitant or reluctant clients to improve individual well-being and create a safer community. A key element of InSPIRE is Enthusiastic Engagement. Enthusiastic Engagement can be defined by daily contacts to build rapport and provide a framework for

voluntary mental health treatment. The goal is to enthusiastically engage individuals to help improve client stability, self-sufficiency, maintain clients engagement in outpatient treatment services, support placement in safe and stable housing environments, and provide individualized safety plans for clients and their family as needed.

Pre-Trial
Pre-Trial services is a partnership between SJC County Probation and BHS that is catered toward individuals pending trial for minor crimes, who struggle with mental illness and/or co-occurring disorder. Treatment services are provided as an alternative to incarceration to reduce the number of people with behavioral health disorders who are in custody pending adjudication.

Misdemeanor IST Diversion
This program is for those diagnosed with mental illnesses or suspected mental illness, like schizophrenia and other psychotic disorders who have committed a criminal act (Misdemeanor) and have been found to be incompetent to stand trial. To be eligible for this program a judge has suspended court proceedings based on competency and has referred the individual to behavioral health for early intervention servicesto determine if a behavioral health disorder is present and if so, to assist with the linkage to appropriate treatment services as well as providing behavioral health services as part of a diversion program.

Felony IST Diversion
The California Department of State Hospitals (DSH) manages the nation's largest inpatient forensic mental health hospital system. DSH's largest patient population includes individuals deemed by the courts to be incompetent to stand trial (IST) and committed to DSH for competency restoration treatment. Individuals who are deemed IST can be restored to competency in inpatient treatment through a DSH facility, outpatient treatment through the Conditional Release Program (CONREP) or diverted into community mental health treatment through DSH's Felony Mental Health Diversion program.

DSH's Felony Mental Health Diversion (Diversion) program, pursuant to Penal Code (PC) section 1001.36 and Welfare and Institutions Code (WIC) 4361, allows felony IST defendants to participate in intensive community mental health treatment in lieu of inpatient DSH competency restoration treatment.

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

Removal Of Children from Home: Primary Measures

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

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

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

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?
Race or Ethnicity
Age

Child Maltreatment Substantiations (CWIP), 2022

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

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

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

Primary Measure: Children in Foster Care, 2025 PIT Count, per 100,000:
San Joaquin's rate of 484 was lower than the Statewide rate of 525, but close to the mean. Rates are highest for children under 2. Rates are higher for females (409) than for males (389), yet both sexes were below the Statewide rate.

Supplemental: Open Child Welfare Case SMHS:
San Joaquin's rate of 45.4% is slightly higher than the Statewide rate of 43%. Rates are lowest among Hispanic children. Rates are lowest among children 0-2 and older youth (18-20). Penetration rates among male children are lower than females and the State average.

Supplemental: Child Maltreatment Substantiations - incidents of children who had an allegation of maltreatment per 1,000. -
San Joaquin's rate of 4.9 is lower than the Statewide rate of 5.7. Children under 2 have the highest rates, with children under 1 having a rate that is more than double the county's average. Black and White children had the highest rates, with Black children having more than double the county's average.

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

Children and Youth Services (CYS) is collaborating with child welfare on Family First Prevention Service Act efforts. Additionally, we will be uplifting (through the RFP process, contracting efforts, and BHSA funding) family focused treatments including Functional Family Therapy, Multi Systemic Therapy, Alternatives for Families -Cognitive Behavioral Therapy, and Hi Fidelity Wraparound focused on improving familial connections and avoiding the need for out of home placement. CYS will begin actively collaborating with the Child Welfare Intensive Family Preservation team. This effort will be focused on providing supportive services to youth and caregivers to avoid removal. Additionally, in the coming fiscal year, CYS will be partnering with Public Health on their prevention efforts including parent support programs.

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

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?
Age
Race or Ethnicity
Spoken Language

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?
Age
Race or Ethnicity

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?
Gender
Race or Ethnicity

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Primary Measure: Follow-up After Emergency Department Visit for Substance Use (FUA-30):
San Joaquin County's rate of 25.1% was lower than the Statewide rate of 28.8%. Demographic groups who had the lowest follow-up rates included adolescents (13-17) and Blacks. Hispanics, Males, and Spanish Speakers had lower than average follow-up rates.

Primary Measure: Follow-up After Emergency Department Visit for Mental Illness (FUM-30):
San Joaquin County's rate of 24.1% was lower than the Statewide rate of 38.2%. Demographic groups who had the lowest follow-up rates included older adults (65+) and Blacks. Adults (18-64) had lower rates than children, and Whites, Males, and English speakers had slightly lower rates than the County rate, overall.

Supplemental: 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:
San Joaquin's overall rate of 59.3% is higher than the Statewide rate of 48.4%. Females and Latinos have higher rates than the overall County average and Statewide average for their respective demographic categories.

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)

The QI Workplan and QAPI department has taken lead on monitoring the improvement of both our Follow-up After Emergency Visit for Substance Use (FUA-30) and Follow-up After Emergency Department Visit for Mental Illness (FUM-30).

Action Plan for FUM-30 - Maintain or increase the percentage of emergency department (ED) visits for which, members 6 years of age or older with a diagnosis of mental illness or any diagnosis of intentional self-harm and had a mental health follow-up service, received follow-up service within 30 days of the ED visit.

• Ongoing, develop resources for obtaining Emergency Department visit information from local hospitals
• Ongoing, develop systems to track follow-up services after an emergency department visit
• Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities.
• Ongoing, work with Managed Care Plans to exchange information

Data Source: CalMHSA Annual HEDIS Calculations; QAPI/Measured quarterly and annually

Action Plan for FUA-30 - Maintain or increase the percentage of members, age 13 and older, who receive a follow up service within 30 days of discharge from an ED for a substance use or drug overdose diagnosis (FUA).

• Develop and implement clinical strategies using ADT data. Specific strategies TBD
• In the first half of 2026, BHS will launch ED follow-up efforts:

1) On-site, pre-discharge – St. Joseph Medical Center: BHS is currently meeting with outreach and social work teams at St. Joseph Medical Center—the highest-volume ED in the county—to clarify roles and responsibilities, prevent service duplication, and ensure continuity of care. The IS department has developed an ED Admission Tracker; pending hospital permissions, BH Access staff will conduct daily rounds, provide field-based screenings, care coordination, and counseling, and document follow-up activities.

2) On-site, pre-discharge – San Joaquin General Hospital: BHS has maintained a substance abuse counselor (SAC) at SJGH for several years. Prior to 2026, the SAC conducted screening and referral without EHR documentation. In early 2026, the SAC received documentation training and began billing services. Due to increased demand, BHS will deploy two additional counselors to support pre-discharge follow-up efforts.

3) Post-discharge follow-up: In early 2026, two HIEs will begin transmitting ED discharge data to SJCBHS. Access staff will be trained to conduct follow-up by phone and document activities in the ED Discharge Tracker. Follow-up will include supporting clients' return to their care teams, providing screening and navigation assistance, and offering brief SUD contemplative counseling to encourage treatment engagement.

Data Source:

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

Please describe other
Administration

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

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

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

For adults/older adults
Below

For children/youth
Same

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

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

For adults/older adults
Above

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?
Above

Overdoses: Primary Measures

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

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

For the full population measured
Above

For adults/older adults
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
Above

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)
Above

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

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

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

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

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

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

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Quality Of Life: Supplemental Measures

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

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

For the full population measured
Same

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured
Below

Suicides: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

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

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

Overdoses

Please describe why this goal was selected
This goal was selected through the combination of community planning and stakeholder input related to overdose concern in the community. The recommendation arose through the discussions around the presentation and interpretation of the Statewide Behavioral Health Goals. San Joaquin County Public Health informed the group that they currently track overdoses in the county with demographic data. We have also chosen this goal as an adjunct to support the efforts of "Follow-up after Emergency Department Visit for Substance Use (FUA-30)". The partnership with both our local hospitals and public health benefits our efforts to strategize interventions for overdose prevention.

BHS QAPI Performance Improvement Project:

In 2023, nearly 70% of U.S. overdose deaths involved fentanyl or similar synthetic opioids (CDC, 2024). Specifically in San Joaquin County, 88% of all opioid overdose deaths in 2024 involved fentanyl. (d) Overdose deaths have increased fastest among Black and American Indian/Alaska Native populations, who often face greater barriers to treatment (CDC Vital Signs, 2022). For example, Black/AA opioid related death rates were about 1.5 percent higher and Native American deaths were almost 4 times higher than White rates(a) San Furthermore, SJCBHS seeks to eliminate statistically significant disparities for gender, race and ethnic groups.

FUA rates are low in SJC mainly because BHS does not receive timely information when Medi-Cal members come to the ED for substance-related reasons. The two HIEs that serve six of the seven county hospitals are not yet sending ADT alerts at admission that include SUD-related presenting complaints. The HIEs also do not yet notify BHS upon or after discharge, when a patient receives a qualifying SUD diagnosis. (b) The primary barriers are the absence of active data feeds and the lack of hospital approval for BHS staff to enter the ED with the highest number of cases. Without admission alerts and approval, BHS cannot identify patients early enough to engage them in person. These barriers prevent BHS from meeting patients where they are—before they return to the community and become harder to contact. (c) These gaps disproportionately affect underserved populations. 2024 CalMHSA HEDIS rate data show lower rates of timely follow-up among Black and Latino members, who also face higher overdose risk. Anecdotal data suggests that members with unstable living situations and co-occurring physical and mental health conditions also have lower rates of follow-up (d) Lower follow-up rates among these populations, reflect practical barriers rather than patients' lack of interest in care. These members are more likely to face access barriers such as unstable housing, limited phone access, changing contact information, transportation or childcare challenges, language barriers, financial strain, or justice involvement. When early ED alerts are missing and outreach occurs only after discharge, these barriers make timely follow-up far less likely and widen existing gaps in care.

The intervention strategy includes two components: (1) pre-discharge ED in-reach and engagement with members presenting to the ED for SUD-related reasons, and (2) post-discharge follow-up for members with qualifying SUD diagnoses. Improving pre-discharge engagement requires finalizing use of HIEs (Bamboo Health and Manifest MedEx); addressing hospital concerns related to consent and BH presence; establishing ED–BHS communication protocols; training staff in culturally sensitive in-reach; and developing standardized documentation and billing workflows. (b) BHS clinicians or SUD counselors will conduct daily on-site engagement at St. Joseph's Medical Center and San Joaquin General Hospital, the two EDs with the highest SUD-related volume, to meet with members prior to discharge. Post-discharge, BHS Access staff will conduct outreach to members discharged from six participating hospitals using Bamboo Health or Manifest MedEx data. Using the BHS ED Admission and Discharge Tracker, staff will determine whether members have already received follow-up care. Active clients will be referred to their care teams; non-active clients will receive up to three outreach attempts offering screening, case management, and navigation support. (c) The interventions will be tested over the 2026 calendar year, and until HIE rates have stabilized beyond the MPL. (d) The BHS ED Tracker facilitates ongoing data compilation, to be reviewed at least quarterly by SJC SUD managers. (e) CalMHSA will calculate FUA rates quarterly and provide demographically disaggregated rates annually.

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

No demographic information was provided through the Statewide BH Goals data presented in the summer.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

This year's plan is to create a collaboration between three system, Public Health, Local Hospitals, and BHS to exchange data related to overdoses in the community, led by our Substance Use Services Division. This collaboration will also be a key stakeholder to the efforts on our FUA 30 PIP. This year's initial collaboration, along with community stakeholders, will inform future programming needed to address overdoses in the community through a data-informed, community driven process for future prevention/early intervention programs through the SUD system of care.

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

BHSA BHSS

Community Planning Process

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

Stakeholder Engagement

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

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

Focus group discussions
Meeting(s) with county
Survey participation
Workgroups and committee meetings
County outreach through townhall meetings
Key informant interviews with subject matter experts

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

Type of engagement
Workgroups and committee meetings

Date
4/25/2024

Type of engagement
Workgroups and committee meetings

Date
7/17/2024

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

Date
10/18/2024

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

Date
12/16/2024

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

Date
2/7/2025

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

Date
3/6/2025

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

Date
4/11/2025

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

Date
4/25/2025

Type of engagement
Focus group discussions

Date
4/1/2025

Type of engagement
Focus group discussions

Date
4/3/2025

Type of engagement
County outreach through townhall meetings

Date
4/8/2026

Type of engagement
Workgroups and committee meetings

Date
4/9/2025

Type of engagement
County outreach through townhall meetings

Date
4/10/2025

Type of engagement
Focus group discussions

Date
4/11/2025

Type of engagement
County outreach through townhall meetings

Date
4/15/2025

Type of engagement
County outreach through townhall meetings

Date
4/22/2025

Type of engagement
Focus group discussions

Date
4/28/2025

Type of engagement
Workgroups and committee meetings

Date
9/3/2025

Type of engagement
Workgroups and committee meetings

Date
9/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/18/2025

Type of engagement
Focus group discussions

Date
11/17/2025

Type of engagement
Focus group discussions

Date
11/19/2025

Type of engagement
Focus group discussions

Date
11/24/2025

Type of engagement
Key informant interviews with subject matter experts

Date
12/8/2025

Type of engagement
Key informant interviews with subject matter experts

Date
12/15/2025

Type of engagement
Key informant interviews with subject matter experts

Date
12/22/2025

Type of engagement
Key informant interviews with subject matter experts

Date
12/23/2025

Type of engagement
Survey participation

Date
10/10/2024

Type of engagement
Survey participation

Date
10/9/2025

Type of engagement
Other

Date
10/10/2024

Type of engagement
Other

Date
10/9/2025

Type of engagement
Workgroups and committee meetings

Date
2/10/2026

Type of engagement
Workgroups and committee meetings

Date
2/19/2026

Type of engagement
Key informant interviews with subject matter experts

Date
2/24/2026

Type of engagement
Workgroups and committee meetings

Date
2/27/2026

Type of engagement
Workgroups and committee meetings

Date
3/18/2026

Type of engagement
Key informant interviews with subject matter experts

Date
3/19/2026

Type of engagement
Workgroups and committee meetings

Date
3/18/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Victor Community Services, United Way, Vivo Community Services, Gibson Center, University of the Pacific, Sow-A-Seed, Catholic Charities, Peer Recovery Services, The Wellness Center, Child Abuse Prevention Council, Prevail, El Concilio, La Familia, NAMI, Telecare, Be Well, Turning Point Community Programs, Veteran's Services, Mary Magdelene, SJC Public Health, Central Valley Low Income Housing Corporation, Partner's Active Care Team, Main Street youth and Family Services, Housing Authority of San Joaquin County, Inspire, SJC Behavioral Health Advisory Board, SJC Office of Education, Consumer Advisory Council, City of Tracy, City of Manteca, City of Stockton, City of Lodi, Stockton Unified School District, Dignity Health, APSARA, CSCDD, San Joaquin Pride Center, Valley Mountain Regional Center, Native Directions, Veteran's Affairs, SJC Probation Department, Service First, Vivo, Little Manila Rising, New Directions, Nirvana, Redwood Family Center, Pinnacle Treatment, Baymark, MedMark; Towns Health Services, Aegis Treatment, United Way, SJC Health Care Services,

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

	City name
1	Stockton
2	Lodi
3	Tracy
4	Manteca
5	Lathrop

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

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
The BHS community planning process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges of consumers receiving mental health and substance use services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the needs of the community: Program Service Assessment, Utilization Analysis, Penetration Rates, Evaluation of Prevention and Early Intervention programs, and Statewide Behavioral Health Goals. BHS also conducted nearly 40 community planning sessions since the passage of Prop. 1 to educate the community of the transition from MHSA to BHSA and to gather feedback related to Housing Intervention, Early Intervention, and important treatment services needed within our community. Community discussions were held in various community forums such as workgroup and committee meetings, key informant interviews, focus group discussions, county outreach through townhall meetings, Training, education, and outreach related to community planning, and survey participation. The highlight of the past two years was our engagement through our Annual 2024 and 2025 MHSA Showcase, promoting and showcasing the important MHSA programs that have been funded through MHSA in past years. The combined showcases were well attended by consumers, family members, providers, and community alike with well over 500+ attendees. In addition to these, BHS

recognizes the meaningful relationship and involvement of stakeholders in the MHSA process and related behavioral health systems. A partnership with constituents and stakeholders is achieved through various committees throughout the BHS system to enhance mental health policy, programming planning and implementation, monitoring, quality improvement, evaluation, and budget allocations. Stakeholders are involved in committees and boards such as: Behavioral Advisory Health Board, MHSA Consortium, Quality Assessment & Performance Improvement (QAPI) Council (including Grievance Subcommittee and QAPI Chairs), Consumer Advisory Committee, Cultural Competency Committee and SUD Monthly Providers Committee. A diverse range of individuals from racial and ethnic backgrounds attended community stakeholder discussions and focus groups. Similar to the County's demographic breakdown and those BHS provides services to, no one racial or ethnic group comprised a majority of participants. Latino/x and African American participants were moderately represented in meetings to express immediate needs in the community, compared to the County population.

Upload File
MHSA to BHSA Community Planning Meeting Notes (Final).pdf
BHSA IP Community Planning Demo Data.pdf

Local Health Jurisdiction (LHJ)

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

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

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
BHS is a key informant to the CHA and CHIP for LHJ's and MCP's. BHS also served a Core Team planning group and a broadly representative Steering Committee. From Data collection and analysis to the identification of prioritized needs, the development of the CHNA report was a collaborative.

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

Collaboration

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

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

Was data shared?
Yes

Stakeholder Activities

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

counties do not need to conduct each of these activities)
Other
Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP
MHP was a key stakeholder in the Community Health Assessment and will be a key stakeholder in the upcoming Community Health Improvement Plan

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

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

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
MHP shared information related to possible Prevention programs that LHJ's can possibly take a lead on, once prevention services funding moves the CDPH.

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
Health Plan of San Joaquin, HealthNet, and Kaiser

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

The MHP and MCP's began our collaboration in January of 2026 to develop synergy around both the Integrated plan and MCP Community Reinvestment. They are invited to continue in the stakeholder engagement through attendance of meetings (very active our Statewide Behavioral Health Goals conversation) and the 30-day public comment period. The MHP will continue to engage and enhance collaboration with the MCP to fortify and strengthen the relationship between our systems.

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 Final Plan

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

Date the stakeholder comment period closed
4/29/2026

Date of behavioral health board public hearing on draft IP
4/29/2026

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
BHSA PUBLIC HEARING FLYER 4.29.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
https://www.sjcbhs.org/mhsa/mhsaplan.aspx

File Upload

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

Attach email
Email to Stakeholders.pdf
BHSA PUBLIC HEARING FLYER 4.29.pdf

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

Stakeholder group that provided feedback
N/A

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

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

Substantive recommendations
N/A

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

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

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

2026 QAPI Work Plan.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	34
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	24
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

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

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

0

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

The county has been engaging and continues to engage our local MCP's (Health Plan of San Joaquin, Healthnet, and Kaiser) to support MCP contracting at provider locations which is focused on good faith efforts to support BHSA-funded SMHS providers to contract with MCP's for NSMHS.

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

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

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

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

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

No

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

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

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

Yes

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

Yes

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

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General

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

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

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

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

TAY Outpatient Care

Seamless transitions between different levels of care are imperative to ensuring youth do not drop out of services. As a youth progresses in treatment, they may no longer need the intensity of services provided in a Full Service Partnership (FSP). This transition of care often results in a new agency and new providers treating the youth. During this transition, many youths opt out of treatment and only return when crisis services are needed. The intent of this program is to encourage continuity of care as youth move go through their process of recovery. This program will be linked to an FSP that will transition youth to their outpatient program as they meet their treatment goals.

Target Population

This program will serve youth ages 16 through 20 who are stepping down from Full Service Partnership Programs (FSP) but still need Specialty Mental Health Services (SMHS) as well as individuals aged 18 and over that would be more appropriate for a TAY-focused program to support them in meeting their goals

Project Components

1. Specialty Mental Health Services
2. Medication management and monitoring services
3. Case Management
4. Assessments
5. Referrals to Vocational and Employment resources

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	50
FY 2027 – 2028	100
FY 2028 – 2029	125

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

Current number of individuals served that the contractor submits to BHS.

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

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

Please select the service types provided under Program

Mental health services
Supportive services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

JCID Restart Program

The Restart program provides a variety of extensive outpatient services and care coordination to help reduce jail and hospital recidivism, reduce time in custody, and reduce overall justice involvement by providing culturally responsive treatment to individuals with behavioral health challenges who are justice involved or at risk of future justice involvement. Through a trauma focused and peer driven lens, participants should reduce criminal activity and improve their quality of life.
The Restart Program is an innovative approach to building a community program to improve care coordination and integration across multiple systems (BHS, Correctional Health, Probation, Courts, etc.). The Program consists of two Mental Health Clinicians, two Mental Health Specialists, and two Mental Health Outreach Workers to serve the justice involved or at risk of justice involved population who are struggling with mental health issues and are 18 years and older, with a focus on supporting people of color, refuges, and those who identify as LGBTQ+ from unserved or underserved communities. The Restart Program provides intensive outpatient services and care coordination in hopes of reducing the following: Jail and hospital recidivism, time in custody, overall justice involvement, and mental health and substance abuse related symptoms; and hopes to improve the client and family experience in achieving and maintaining wellness and recovery. The Restart Program also provides linkages to housing and employment resources, culturally appropriate treatment, and peer-support services; with an overall goal towards assisting justice involved or at risk of justice involved clients to achieve and maintain wellness.
Target Population
Adults (18-59) and Older Adults (60+) with SMI or Co-Occurring Disorder, justice involved or at risk of justice involvement.
Project Objectives

• Improve the client and family experience in achieving and maintaining wellness and recovery
• Improve care coordination and integration across multiple systems.
• Increase client's ability for self-advocacy.
• Decrease barriers to accessing and receiving services.
• Decrease risk of justice involvement
• Decrease recidivism rates.

Project Goals

1. Increase mental health stabilization as evidenced by a decrease in overall justice involvement, with a goal of 60% or more of active clients not picking up new charges while receiving Restart services.
2. At least 50% of active clients will improve their knowledge and ability on accessing community services.
3. Less than 20% of active clients will access crisis services.
4. At least 50% of active clients who identify housing as a need will obtain or retain shelter (permanent or temporary).
5. The Restart Program will maintain an annual consumer satisfaction level of 75% of those completing the survey.

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	315
FY 2027 – 2028	330
FY 2028 – 2029	350

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

Based on current staffing and members served in previous years

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
Mental health services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided
Employment Recovery Services

Project Description
Supported Employment is an approach to vocational rehabilitation for people with serious mental illnesses that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace. The overriding philosophy of Supported Employment is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Supported Employment is not designed to change consumers, but to find a natural "fit" between consumers' strengths and experiences and jobs in the community.

Project Goal: The goal of this project is to increase the numbers of mental health consumers that are employed and/or involved in education.
The project is intended to result in the following outcomes for mental health consumers participating in the project:
- Increased competitive employment among consumers;
- Increased independent living;
- Increased educational involvement;
- Increased self-esteem; and
- Increased satisfaction with finances.

Target Population
The target population will be seriously mentally ill adults (ages 18 and older) that are enrolled in or are transitioning to or from the County's Full-Service Partnership programs and their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance use disorders.

Project Components

The Employment Recovery Services project will be based on the Evidence-Based Practices Kit on Supported Employment issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)

• Assertive Engagement and Outreach: Make multiple contacts with consumers as part of the initial engagement and at least monthly on an ongoing basis when consumers stop attending vocational services.

• Vocational Profiles: Conduct individualized interviews with each consumer to determine their preferences for type of employment, educational and work experiences, aptitudes and motivation for employment. Vocational profiles will be consumer driven and based on consumers' choices for services. Vocational assessment will be an ongoing process throughout the consumer's participation in the program.

• Individual Employment Plans: In partnership with each consumer, prepare an Individual Employment Plan, listing overall vocational goals, objectives, and activities to be conducted. Assist consumers with resume development and interviewing skills as needed.

• Personalized Benefits Counseling: Provide each consumer with personalized information about the potential impact of work on their benefits.

• Job Search Assistance: Help consumers explore job opportunities within one month after they enter the program. Provide job options in diverse settings and that have permanent status. Employer contacts will be based on consumers' job preferences.

• Continuous Supports: Provide continuous support for employed consumers that include the identification and reinforcement of success as well as coaching when concerns arise. Help consumers end jobs when appropriate and then find new jobs.

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	100
FY 2027 – 2028	150
FY 2028 – 2029	200

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

Based on current staffing and members served in previous years

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

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

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

Please describe the specific services provided
Crisis Services Expansion Program

The Crisis Unit provides a 24/7 crisis response for any individual experiencing a mental health emergency in San Joaquin County. Crisit services expansion program has three components

Project Components

Component 1: Capacity Expansion
Prior to the passage of the Mental Health Services Act in November 2004, the BHS Crisis Unit operated M-F from 7am – 11pm. Staffing was limited and waiting times were very long. MHSA funding created a full-service Mental Health Crisis Unit for San Joaquin County that is open 24/7, 365 days a year.
The expanded crisis unit boasts more robust staffing, reducing waiting times. It has a new medication room, eliminating the need to wait for the pharmacy to open for the team to dispense medications. Services are expanded with a new triage unit, ensuring all clients receive a warm welcome and a brief screening within a timely fashion. Enhanced discharge services make it possible for clients to receive aftercare support and a warm connection to continuing services through the Outpatient Clinics. New discharge services include post-crisis or -hospitalization transportation home, and transport to initial outpatient appointments, if necessary.

Component 2: Warm Line
The BHS Warm Line is a 24-hour service that provides consumers and their family members with 24/7 telephone support to address a mental health concern. The Consumer Support Warm-Line is a friendly phone line staffed with Mental Health Outreach Workers who provide community resources and give support and shared experiences of Hope and Recovery. Consumers and their families can obtain referrals,

share concerns, receive support, and talk with a Mental Health Outreach Worker who generally understands their perspective, and is willing to listen and talk with them.

Component 3: Crisis Community Response Teams (CCRT)
CCRT clinicians respond to emergency requests from law enforcement for immediate, on-site mental health crisis services, including mental health evaluations for temporary, involuntary psychiatric inpatient care in situations where the mental health consumer is a danger to self, danger to others or gravely disabled.
The CCRT also works in coordination with local hospital emergency rooms. Hospitals providing medical care may call the CCRT to request a crisis evaluation for any person at the hospital who has already been medically cleared (ready for discharge), and who may be a danger to self, others or gravely disabled due to a mental disorder. CCRT clinicians work with hospital staff to determine the appropriate level of intervention needed, including transport to a crisis stabilization unit and/or a psychiatric health facility. BHS operates two Crisis Community Response Teams. Services are available 24/7.

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	3600
FY 2027 – 2028	3700
FY 2028 – 2029	3800

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
Based on current staffing and members served in previous years

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

CARES/CARES+

CARES Plus: The CARES Plus Component provides timely, coordinated, comprehensive, and community-based mental health services, linkage, advocacy, and support to Medi-Cal beneficiaries ages 6 to 18. The goal of the program is to take a proactive approach to identifying and addressing mental health issues for youth who are at risk of exposure to adverse childhood experiences and traumatic childhood events, environmental trauma including community violence, generational trauma, institutional trauma, and prolonged toxic stress through early intervention services provided by clinicians and mental health specialists. A diverse array of mental health and rehabilitation services will be offered including: Individual Therapy, Family Therapy, Group Therapy, Skill building, and Case Management. For youth that demonstrate a need to be linked to a higher level of care (i.e. medication/psychiatric evaluation) staff will assist and support with linkage, as needed. Components of the program include:

Child Mind Institute Mental Health Skill Building Component: this curriculum is grounded in the principles of Cognitive Behavioral Therapy and Dialectical Behavioral Therapy. It is tailored to the developmental needs of children and youth and shared by their diverse identities, lived experiences, and cultural strengths. It can be administered by way of individual or group settings. This evidence-based curriculum focuses on teaching children and youth how to develop positive self-awareness, effective communication, emotional regulation, and decision-making skills.

Outreach and Engagement Component:
Outreach and engagement efforts are focused on identifying and addressing mental health issues among individuals who may be at risk. Interventions include outreach, and access and linkage.

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
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
Dialectical Behavior Therapy
Mental Health SkillBuilding and Mood Intervention

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Child Mind Institute Mental Health Skill Building Program

Please describe intended outcomes of the program or service
The goal of the program is to take a proactive approach to identifying and addressing mental health issues for youth who are at risk of exposure to adverse childhood experiences and traumatic childhood events, environmental trauma including community violence, generational trauma, institutional trauma, and prolonged toxic stress through early intervention services provided by clinicians and mental health specialists. A diverse array of mental health and rehabilitation services will be offered including: Individual Therapy, Family Therapy, Group Therapy, Skill building, and Case Management. For youth that demonstrate a need to be linked to a higher level of care (i.e. medication/psychiatric evaluation) staff will assist and support with linkage, as needed.

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	120
FY 2027 – 2028	150

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

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on current staffing and members served in previous years

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
Misdemeanor IST Diversion

San Joaquin County Behavioral Health has developed a Misdemeanor Incompetent to Stand Trial (MIST) Program to serve individuals whose untreated mental health conditions contribute to repeated arrests, inability to participate in court proceedings, and increased risk of homelessness or deeper system involvement.
This program offers intensive behavioral health treatment, stabilization, and community based supports to reduce recidivism, improve functioning, and provide the court with alternatives to incarceration or state hospital placement.
The program is a collaboration between the District Attorney, Public Defender, Probation, the Court, Behavioral Health Services, and community partners.

Program Purpose
• Provide treatment and stabilization for individuals found misdemeanor IST
• Reduce jail days and unnecessary incarceration
• Address psychiatric symptoms contributing to justice involvement
• Reduce recidivism and prevent escalation to felony charges
• Support the court in identifying diversion, dismissal, or alternative resolutions
• Promote long term recovery, housing stability, and community integration

Core Components:

1. Early Identification & Screening
• Behavioral health screening at custody or court remand
• Rapid assessment of symptoms, impairments, and treatment needs
• Determine appropriateness for diversion or stabilization services

2. Intensive Case Management
• FSP aligned “whatever it takes” approach
• Frequent, low demand engagement in the community
• Transportation, appointment support, and daily living assistance

3. Treatment & Stabilization
• Psychiatric evaluation and medication support
• Symptom stabilization and management
• Psychoeducation on wellness, coping, and functioning
• Rehabilitative groups and activities
• Substance use treatment linkage
• Peer support

4. Housing & Benefits Support
• Access to the county’s housing continuum (SLE → B&C → transitional)
• Assistance with Medi Cal, SSI, CalFresh, and essential benefits

5. Crisis Response & Linkage to Higher Levels of Care
• Staff trained to recognize escalating symptoms, safety concerns, or functional decline
• Immediate coordination with the Crisis programs- Mobile Crisis Support Team/Mobile Crisis Response Team for evaluation when an individual presents a risk to self, others, or grave disability
• Escorting clients to Crisis for assessment when clinically indicated
• Collaboration with Crisis clinicians to determine the appropriate level of care (e.g., outpatient stabilization, crisis residential, inpatient psychiatric care)
• Ensuring continuity of care by coordinating discharge planning and re engagement with the MIST Diversion team after crisis intervention

6. Court Collaboration & Reporting
• Regular updates to the court on treatment engagement and stability
• Recommendations for diversion, dismissal, or alternative resolutions
• Coordination with DA/PD on legal pathways that do not require restoration

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

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

Please specify "other" type of Treatment Services and Supports

Individualized Case Management, Rehab groups and activities, peer support

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

Yes

Please select the EBPs and CDEPs that apply

Cognitive Behavioral Therapy (CBT) for Psychosis
Seeking Safety (SS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Cognitive Behavioral Therapy (CBT)

Please describe intended outcomes of the program or service

Clinical & Functional Outcomes
• Improve clinical stability and reduce psychiatric symptoms
• Increase daily functioning and independence
• Support members in defining and building a meaningful, self directed life

Justice System Outcomes
• Reduce recidivism
• Reduce the number of misdemeanor IST referrals to State Hospitals

• Reduce CARE Court involvement through early stabilization
• Reduce criminal activity
• Prevent unnecessary incarceration and reduce jail days

Housing & Resource Outcomes
• Prevent homelessness through timely housing linkage
• Connect members to appropriate wraparound services and community supports
• Increase access to benefits, medical care, substance use treatment, and peer support

Crisis & Safety Outcomes
• Identify early signs of deterioration and link members to crisis level care when needed
• Ensure continuity of care following crisis intervention or hospitalization

• Enhance public safety by stabilizing individuals in the community and reducing crisis driven law enforcement contact

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	45
FY 2027 – 2028	48
FY 2028 – 2029	51

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on potential staffing and possible members meeting qualifications for the program

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
Early Intervention for Older Adults

Community stakeholders and older adults have expressed the need for early intervention services for older adults in San Joaquin County. Older adults, those aged 60 or above, may suffer from undiagnosed developing mental health disorders. As a growing age group in San Joaquin County, it is imperative to provideservices to those individuals in need of additional prevention and early intervention supports by skill building and early intervention supports.

Target Population:
Older Adults (60+ years old), including individuals from underserved populations such as Latino, Asian, African American, LGBTQ, low income, and geographically isolated.

Project Description
BHS has implemented the Program to Encourage Active, Rewarding Lives (PEARLS), evidence-based program, to educate older adults about depression (and is not) and helps them develop skills they need for self-sufficiency and more active lives. This program takes place in six to eight sessions over the course of four to five months in an older adult's home or a community-based setting that is more accessible and comfortable for older adults who do not see other mental health programs as a good fit for them.
• PEARLS is an effective skill-building program that helps older adults manage and reduce their feelings of depression and isolation
• PEARLS adapts to the participant and the place and the need
• PEARLS is adaptable to various community needs and helps expand access to depression care in underserved communities, including rural ones.
• PEARLS meets older adults where they are, especially those who have limited access to depression care because of systematic racism, trauma, language barriers, low income, and other factor leading to determinants of health

Project Components:

Program staff will be fully trained in the evidence-based model for PEARLS. The PEARLS program will be the catalyst for initial engagement with the older adult population to provide key skill building supports and provide access to timely medically necessary early intervention services.

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

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

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

Yes

Please select the EBPs and CDEPs that apply

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Please describe intended outcomes of the program or service

Project Components:
Program provider will be fully trained in the evidence-based model for PEARLS. The PEARLS program will be the catalyst for initial engagement with the older adult population to provide key skill building supports and provide access to timely medically necessary early intervention services.
Program Goals
• Early identification of mental/emotional difficulties and increased timely access to medically necessary services
• Increased provider awareness of the mental health needs of older adults and linkage to appropriate community resources
• Reduced prolonged suffering by increasing protective factors and reducing risk factors

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	65
FY 2027 – 2028	70
FY 2028 – 2029	75

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on current staffing and members served in previous years

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
Dependency Intake Team

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

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
Members served by this program are involved with the child welfare system. The purpose of the Dependency Intake team is to provide an intensive level of engagement and stabilization services while working in a cross-system, cross-agency team environment that more effectively and efficiently addresses concurrent and complex child, youth, and family needs. Trained clinical staff provide trauma-informed, evidence-based services and supports to include full biopsychosocial assessment, individual therapy, Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) anchored in the principles and values of the Core Practice Model. The Child and Family Team (CFT) meeting along with the CANS will be used to address emerging issues, provide integrated and coordinated interventions, and refine and inform the plan and services as needed.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	400
FY 2027 – 2028	450
FY 2028 – 2029	500

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on previous year data and projected individuals to be served by program.

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
Functional Family Therapy

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
Functional Family Therapy (FFT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Functional Family Therapy (FFT)

Please describe intended outcomes of the program or service
Functional Family Therapy (FFT) is an effective, short-term evidence-based family counseling service designed for 11-to-18-year-old youth who are at risk or have been referred for behavioral or emotional problems. FFT works with a young person's entire family and extrafamilial influences to facilitate positive growth and development.
FFT is based on a respect- and strength-based process. FFT interrupts negative interaction patterns while

also validating the negative impact of behavior. FFT sessions are conducted in the home or community setting and are typically spread over a 3-month period. The total number of sessions may vary depending on the family's needs.
The goals of FFT include: reduce conflict, hostility, and blame, increase hope and build alliances, improve communication and supportiveness, decrease dysfunctional behaviors, and improve parenting skills.
The target population for FFT includes youth who have been referred by the juvenile justice, mental health, school, or child welfare systems, youth with disruptive, externalizing problems and youth at risk of or already involved in violence, crime, or substance abuse.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	50
FY 2027 – 2028	100
FY 2028 – 2029	130

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on potential staffing and possible members meeting qualifications for the program

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
Multisystemic Therapy

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
Multisystemic Therapy (MST)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Multisystemic Therapy (MST)

Please describe intended outcomes of the program or service
Multisystemic Therapy (MST) is an evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood and community) that contribute to, or influence an individual's involvement, or potential involvement in the juvenile justice system. The target age range is youth 12-17 but youth of other ages can receive the service if medically necessary.
The therapeutic modality uses family strengths to promote positive coping activities, works with the caregivers to reinforce positive behaviors, and reduce negative behavior, and helps the family increase accountability and problem solving. Individuals and families participating in MST receive assessment and home based treatment that strives to change how the individuals, who are at risk of out-of-home placement, or who are returning home from an out of home placement, function in their natural settings to promote positive social behavior while decreasing anti-social behavior.
MST's therapeutic model aims to uncover and assess the functional origins of adolescent behavioral problems by altering the individual's behavior in a manner that promotes prosocial conduct while decreasing aggressive/violent, antisocial, substance using and/or delinquent behavior by keeping the individual safely at home, in school and out of trouble.

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	35
FY 2027 – 2028	50
FY 2028 – 2029	75

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on potential staffing and possible members meeting qualifications for the program

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
Parent-Child Interaction Therapy (PCIT)

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
Parent Child Interaction Therapy (PCIT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Parent Child Interaction Therapy (PCIT)

Please describe intended outcomes of the program or service
Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. The primary target group for PCIT is children between 2 and 7 years old.
PCIT is based on many of the same theoretical underpinnings as other parent training models. However, the treatment format differs from many other behavior parent training programs that take more of a didactic approach to working with families. Specifically, parents are initially taught relationship enhancement or discipline skills that they are actually going to be practicing in session and at home with their child.
In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a “bug-in-the-ear” system for communicating to the parents as they play with their child.
Traditional PCIT also differs from other parent training treatment strategies in that treatment is not session-limited. Specifically, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits. As the parent/caregiver is required to actively participate in sessions, providers are required to make child care available to consumer’s family members as needed during sessions.

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	30
FY 2027 – 2028	50
FY 2028 – 2029	70

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on potential staffing and possible members meeting qualifications for the program

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
Partners Active Care Team (PACT)

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
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)

Please describe intended outcomes of the program or service
This team provides intensive clinical treatment services for children and youth that are at risk for and/or presenting with delinquency, violence, substance use, mood disturbances, anxiety symptoms, or trauma with the goal of reducing prolonged suffering, incarcerations, and school disruption. Therapy and skill building and case management services will be provided by mental health clinicians and paraprofessionals. Length of stay is 6-12 months.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	40
FY 2027 – 2028	70
FY 2028 – 2029	100

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on potential staffing and possible members meeting qualifications for the program

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 Support and Response Team

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
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Outreach

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

Please select the EBPs and CDEPs that apply
Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Motivational Interviewing

Please describe intended outcomes of the program or service

Mobile Crisis Support and Mobile Crisis Response Teams (MCSTs and MCRT's) provide on-site mental health assessment and intervention within the community for individuals experiencing mental health issues and to avert a mental health related crisis. MCST/ MCRT help avert hospitalizations and incarcerations by providing early interventions to individuals who would not otherwise be able to seek help at traditional service locations.
MCST/MCRT transition individuals to appropriate mental health crisis interventions in a timely fashion, reducing dependency on law enforcement and hospital resources. Comprised of a clinician and a peer- or parent-partner, MCSTs provide a warm handoff to services and help educate and introduce individuals and their family to the most appropriate services in a calm and supportive manner.
Target Population
• Individuals who are known to have serious mental illness and are substantially deteriorating or experiencing an urgent mental health concern.
• Individuals who are suspected of having a serious mental illness who may be unconnected to a mental health care team.
Project Components
• BHS operates four mobile crisis support teams.
• Services are available daily (Monday – Sunday), and into the evening hours most days of the week.
MCST/MCRT conduct same day and follow-up visits to individuals that are experiencing a mental health crisis and require on-site, or in-home, support and assistance. MCST/MCRT conduct mental health screenings and assessments to determine severity of needs and help transition individuals into routine outpatient care 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	2797
FY 2027 – 2028	0
FY 2028 – 2029	3083

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on previous year data and projected individuals to be served by program

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
The Wellness Center

The Wellness Center is a consumer operated program that provides an array of recovery support services. The Wellness Center provides classes and information on services and support available in the community, self-help and peer-support group activities, training and workshops to promote long term recovery and well-being on a variety of topics: from positive parenting to nutrition and active lifestyles, to job development skills. The Wellness Center provides scheduled and drop-in services and programming that is respectful and representative of the diversity of consumer members.
Peer Recovery Services (PRS) will provide services from The Wellness Center (TWC) in Central Stockton, accessible to consumers of mental health services, regardless of where that consumer receives on going mental health treatment.).
Peer Recovery Services (PRS) staff providing services to mental health consumers will be Peer Support

Specialists. Services provided may be one-on-one or in a group format.

Project Goal
The primary objectives for this program will be to:
• Provide a consumer-driven self-help service center in close collaboration with consumers, family members and BHS.
• Increase opportunities for consumers to participate in activities that promote recovery, personal growth, and independence.
• Increase leadership and organizational skills among consumers and family members.

Target Population(s)/ Eligibility Criteria:
TWC will serve all adult (18 years and above) mental health consumers in the community, regardless of what entity or agency provides their primary mental health care. Staff of TWC will have knowledge of other community resources to make referrals to programs that can better address the special needs of households with children or consumers who are under 18 years of age.

Referrals:
TWC will serve mental health consumers on a walk-in or scheduled basis, providing one-on-one or group activities. Referrals for Medi-Cal billable groups will be provided and monitored by San Joaquin County Behavioral Health Services (BHS).
In the event TWC has a consumer in need of Specialty Mental Health Services, they will link consumer to BHS Access for a screening. In the event a consumer is in a state of crisis, they will link consumer to BHS Crisis.

Services Provided:

1. Consumer Leadership: TWC will provide leadership opportunities through support provided to the:

a. Power 'N Support Team, a consumer group separate from TWC structure but which is provided meeting space on-site. Consumers will actively participate through surveys and focus groups to provide input on which groups and classes should be offered and what supports are most valuable. All TWC staff and volunteers will continue to be recruited from among the targeted population.

b. Consumer Advisory Council (CAC) Coordination – Coordinate consumer led advisory group separate from TWC structure. Consumers in the CAC will facilitate communication between consumers/family members and BHS Administration, provide guidance and support to the consumer/family members, assist consumers to grow toward self-empowerment, wellness and recovery, and represent consumers in various BHS led efforts of consumer input, committee meetings and community engagement. CAC meeting

attendees receive a stipend for each meeting they attend.

Peer Advocacy: One of the major roles of TWC Peer Recovery Services staff will be to assist individual consumers with everyday issues. Information and assistance ranges from dealing with Social Security Administration questions, how to obtain identification, services available from Behavioral Health Services (BHS) and how to access those services, resolving conflicts with others, and how to be a better self-advocate. Peer support, advocacy services and non-clinical peer counseling will occur as needs are identified. All peer services will be oriented toward strengthening tools of recovery. Presentations on specific subject matters will occur on a regular basis.

Specialized information regarding housing and tenant rights issues, alternative housing support opportunities, where and how to seek employment, the impact employment may have on other benefits, and access to childcare opportunities will be provided directly by Peer Recovery Services staff and by partnering agencies and programs.

TWC staff will provide consumers with information on using public transportation and provide bus passes [TD1.1]to assist with transportation needs. TWC also operates a van that provides transportation to assist consumers in participating in activities, accessing the Food Bank, and addressing medical needs.

Peer Classes and Coaching: TWC will provide a wide range of groups and classes designed to improve independent living and coping skills. Topics may include: recovery concepts, anger management, arts & crafts, peer support, self-esteem & life skills, spirituality, women's issues, men's issues, dual discovery, health & wellness, nutrition & cooking, and basic budgeting & money management.

In addition to regular classes, TWC will provide a computer center and small library for use by consumers. Peer Recovery Services staff will assist consumers in learning about basic computer operations, improving basic computer skills and internet access; the library contains materials that assist consumers in understanding their illness and finding strategies to deal with common issues.

Outreach: In order to facilitate participation in Wellness Center activities by consumers in rural areas of the county, the PRS van(s) will be available to provide transportation from locations throughout San Joaquin County as needed.

TWC sites will work with BHS Full Service Partnerships and related community organizations to inform consumers of opportunities at the Center and to encourage participation in Wellness Center activities.

TWC staff will develop supportive relationships with housing programs that serve individuals with mental health conditions, offering peer support services. TWC will also explore the possibility of using BHS clinic sites and similar locales in the county to provide services at those locations.

Volunteer program: TWC will continue to use the curriculum developed in 2012 for orientation and training of consumers interested in becoming volunteers, along with volunteer job descriptions for a variety of tasks involving activity support, facilitation support, transportation support, and community outreach activities. Volunteer recruitment, orientation, and training occur on a regular basis. Volunteers are used to help supplement TWC activities. [TD2.1]Volunteers receive a monthly stipend.

TWC will provide Medi-cal billable services to BHS members utilizing certified Peer Support Specialists. Peer Support Specialists will provide Medi-Cal Peer Support Services in various BHS facilities throughout San Joaquin County. These services may be one-on-one with BHS members or in a group format with BHS members.
Medi-Cal Peer Support Services are defined as Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:
Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

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

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

Please select the EBPs and CDEPs that apply
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Seeking Safety (SS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Motivational Interviewing
Seeking Safety

Please describe intended outcomes of the program or service
Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:
Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and

collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	200
FY 2027 – 2028	210
FY 2028 – 2029	220

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on previous programming with the Wellness Center and addition of peer support services.

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
Whole Person Care

Individuals with mental illnesses are at high risk of becoming homeless. Individuals who are homeless are at greater risk of being unserved or underserved by mental health services. In San Joaquin County approximately 30% of homeless individuals are believed to have some level of mental health concern.

Targeted efforts are needed to help homeless individuals, and those at risk of homelessness upon discharge from an institution, access services including behavioral health treatment.

Project Description
The Whole Person Care project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services. Program services target those who over-utilize emergency department services, have a mental health and/or substance use disorder, or are homeless or at risk for homelessness upon discharge from an institution.

BHS Linkage and Treatment Team:

BHS Linkage Team and Treatment will work with homeless outreach team to provide street outreach, communication and coordination with law enforcement partners, enthusiastic engagement and screening for behavioral health concerns, transport to clinic or other locations for psychosocial assessments, ongoing case management, be the warm hand team to receive referrals from the community into treatment services, family engagement / reunification opportunities.

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

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
Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Motivational Interviewing

Please describe intended outcomes of the program or service
To increase pathways to service and test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services. Program services target those who over-utilize emergency department services, have a mental health and/or substance use disorder, or are homeless or at risk for homelessness upon discharge from an institution.

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	150
FY 2027 – 2028	200
FY 2028 – 2029	250

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on current staffing and members served in previous years

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 Services/ Point of Entry Expansion - ED Response Team

The intervention program includes two components: (1) pre-discharge ED in-reach and engagement with members presenting to the ED for MH and/or SUD-related reasons, and (2) post-discharge follow-up for members with qualifying MH and/or SUD diagnoses. Improving pre-discharge engagement requires finalizing use of HIEs (Bamboo Health and Manifest MedEx); addressing hospital concerns related to consent and BH presence; establishing ED–BHS communication protocols; training staff in culturally sensitive in-reach; and developing standardized documentation and billing workflows. (b) BHS clinicians, Specialist or SUD counselors will conduct on-site engagement, Monday-Friday at St. Joseph’s Medical Center and San Joaquin General Hospital, the two EDs with the highest MH and SUD-related volume, to meet with members prior to discharge. Post-discharge, BHS Access staff will conduct outreach to members discharged from six participating hospitals using Bamboo Health or Manifest MedEx data. Using the BHS ED Admission and Discharge Tracker, staff will determine whether members have already received follow-up care. Active clients will be referred to their care teams; non-active clients will receive up to three outreach attempts offering screening, case management, and navigation support. (c) The interventions will be tested over the 2026 calendar year, and until HIE rates have stabilized beyond the MPL. (d) The BHS ED Tracker facilitates ongoing data compilation, to be reviewed at least quarterly by SJC managers. (e) CalMHSA will calculate FUM and FUA rates quarterly and provide demographically disaggregated rates annually.

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

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

San Joaquin County aims to improve follow-up within 30 days of emergency department visits for mental health and substance use

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	400
FY 2027 – 2028	600
FY 2028 – 2029	800

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on staffing and potential members that need an ED response team to navigate and provide BH services.

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
Early Interventions to Treat Psychosis

CSC program description
The Early Interventions to Treat Psychosis (EITP) program provides an integrated set of promising practices that research has indicated will slow the progression of psychosis, early in its onset. The EITP program will offer a combination of outreach, engagement, and evidenced-based treatments and supports, delivered to individuals throughout San Joaquin County who have experienced their first full psychotic episode in the

past two years or who are showing prodromal symptoms of psychosis.

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	130
Number of Uninsured Individuals	14

CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	17
Number of Teams Needed to Serve Total Eligible Population	4

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	12	12	12
Total Number of Teams	2	2	2

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

County Workforce, Education, and Training (WET) Program

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

Program or activity name
Behavioral Health Workforce Partnershp

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 county continues to have a diverse population of workforce, as our recent staff survey shows:

White (e.g. German, Irish, English, Italian, Polish, French, etc.) 32.64%
Hispanic or Latino (e.g. Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, etc.) 29.50%
Black or African American (e.g. African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.) 14.23%
Asian or Asian American (e.g. Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.) 24.48%
American Indian or Alaska Native (e.g. Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Tribal Government, Tlingit, etc.) 5.65%
Middle Eastern or North African (e.g. Lebanese, Iranian, Egyptian, Syrian, Moroccan, Israeli, etc.) 0.42%
Native Hawaiian or Pacific Islander (e.g. Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.) 2.51%
Prefer Not to Say 3.35%
Another race (please specify) 3.56%

The county will continue to recruit, train, and retain diverse staff to meet the needs of the San Joaquin diverse community.

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
Netsmart

Please select the type of project
Technological needs project

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

Please describe the project
Implementation of New Electronic Health Record System for the MHP

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
Be Well Campus

Please select the type of project
Capital facilities project

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

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

Please describe the project
The Be Well Campus is a new facility in French Camp that will expand access to mental health and substance use disorder treatment in the Central Valley. The campus will include 10 facility types, with 116 behavioral health treatment beds and 1,205 outpatient slots, enabling care for than 72,000 individuals annually.

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

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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	2182
Number of Uninsured Individuals	333

Total Adult FSP Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	775

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	293
Number of Uninsured Individuals	45

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	147
Number of Uninsured Individuals	22

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	60
Number of Teams Needed to Serve Total Eligible Population	<11*

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	45	49	56
Total Number of Teams	5	5	6

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	1743
Number of Uninsured Individuals	266

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	85
Number of Teams Needed to Serve Total Eligible Population	17

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	31	33	35

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

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	618
Number of Uninsured Individuals	111

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	232
Number of Teams Needed to Serve Total Eligible Population	11

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and 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	30	40	50
Total Number of Teams	6	8	10

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	3287
Number of Uninsured Individuals	519

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	240
Number of Teams Needed to Serve Total Eligible Population	96

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	5	5	5
Total Number of Teams	1	1	1

Full Service Partnership (FSP) Program Overview

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

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

No

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

FSP program staff will evaluate the needs and orient the eligible member to the program philosophy and process; providing enough information so that the member can make an informed choice regarding enrollment. This process is used to explore the natural supports individuals have to build into recovery efforts, including family and community supports, and to further understand treatment needs. A whole-person, trauma-informed collaborative discussion is provided to enhance clinical treatment. Clinicians will conduct comprehensive clinical assessments to make recommendations for treatment and service interventions which are outlined in the Client Treatment Plan.

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

FSP program services are available to all individuals that meet the clinical eligibility criteria for specialty mental health care and full-service partnership programming without regard to the person's race, color, national origin, socio-economic status, disability, age, gender identification, sexual orientation, or religion. All program partners are required to take reasonable steps to ensure that organizational behaviors, practices, attitudes, and policies respect and respond to the cultural diversity of the communities and clients served.

FSP program services are delivered in a manner which factors in the language needs, health literacy, culture, and diversity of the population that is served. Information and materials are available in multiple languages and trained mental health translators are assigned as needed to ensure comprehension and understanding by the clinical team of the client's recovery goals and agreement or adherence to the treatment plan. All program partners are required to provide meaningful access to their programs by persons with limited English proficiency.

FSP programs also offer a range of culturally competent services and engagement to community-based resources designed for:

- African American consumers
- Asian / Pacific Islander consumers, including services in:
  - Cambodian / Khmer
  - Hmong, Laotian, Mien
  - Vietnamese
- Latino/Hispanic consumers, including services in
  - Spanish
- Lesbian, gay, bisexual and transgender consumers
- Middle Eastern consumers
- Native American consumers

BHS is continually striving to improve cultural competence and access to diverse communities. All partners are expected to provide meaningful linguistic access to program services and to address cultural and

linguistic competency within their organization.

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

Access to care
Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions
Overdoses

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

FSP Engagement:
• Enthusiastic Engagement: Enthusiastic engagement refers to a program strategy that supports daily attempts at contact and finding creative pathways to treatment services for hesitant or reluctant members.
• Transition to Treatment: Individuals that are treated within the BHS crisis continuum (Crisis Services, Crisis Stabilization Unit, or Psychiatric Health Facility) are discharged with a transition to treatment plan that includes a scheduled follow-up appointment and linkage to routine services. Peer navigators are also a part of the transition to treatment process following a crisis episode and may be a component of the discharge plan.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

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

The county is implementing and restructuring FSP programs to meet the required FSP Levels of Care in each of the respective FSP programs

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

Yes

Primary substance use disorder (SUD) FSPs
Yes

If Yes, please describe
The Co-Occuring SUD FSP program will be our first Primary SUD FSP. It converts an existing MH/SUD Co-Occuring program to a Primary SUD and Co-occuring MH FSP Program. The enhancement of the program increases our cadre of services for our SUD primary members that require a more intensive level of outpatient treatment for SUD diagnoses.

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

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
The county will utilize the BHSA outreach Team, CYS Cares Team and Whole-Person Care Team to meaningfully engage individuals in the community to create a warm hand referral to FSP programs for potential members in need of significant behavioral health needs.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
Outreach and Engagement, Recovery Support Services. Each FSP will include substance abuse counselor as part of the FSP team to engage members that are assessed to have a co-occuring SUD diagnosis offering recovery oriented services and coordination with additional SUD related services.

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"
• Peer support services
• Housing navigation and tenancy support services
• Benefits assistance (Medi Cal, SSI/SSDI, CalFresh)
• Vocational, educational, and volunteer linkage
• Life skills development (ADLs, budgeting, transportation, community navigation)
• Wellness and resiliency activities

• Social and community integration opportunities
• Field based outreach and engagement
• Crisis linkage and post crisis re engagement

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
CYS engaged by reviewing data, engaging with stakehlders (parents and families, cbo's, probation partners,

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Analyze Prevention Demographics Data, Intake and assessment processes, engage with parents, families and members of the members that identified within the community.

In the child welfare system
Bi-monthly child welfare meetings, review data, engage with HSA partners.

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
The county continues to uplift the Older Adult Early Intervention program called PEARLS. This program will now convert to an Early Intervention program to provide a more robust cadre of services who suffer from depression and isolation. Since 2021 and the aftermath of Covid, the older adult population in San Joaquin County needed a program to provide direct support for those that suffered from a mental health challenge due to the pandemic. In 2023, BHS started the PEARLS prevention program to provide such a resource for the older adult population.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Engaged members of the community through outreach and engagement and attendance of community planning stakeholder events. Continuous feedback via the BHSA Consortium with representatives from both the San Joaquin Pride Center and the Central Valley Gender and Wellness Center. In 2025, the county hosted a pride month clinic competition to highlight LGBTQ+ diversity to create safe spaces within our clinics. Members and allies of the LGBTQ+ community are well represented in our various BHS Committees.

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

The county behavioral health system incorporated the unique needs of justice involved adults into the design of its FSP programs through a combination of collaboration, field based engagement, culturally responsive practices, and justice system specific service planning. Key actions included:

• Cross system collaboration

The county partners with the Courts, Probation, Public Defender, District Attorney, law enforcement, and community providers to understand the behavioral health, legal, and functional needs of adults cycling through the justice system.

• Identification of barriers specific to justice involved adults

The county assessed barriers such as homelessness, untreated mental illness, substance use, lack of benefits, transportation challenges, and limited natural supports. These findings shaped the FSP model to ensure rapid access to treatment, housing, and stabilization services.

Integration of field based and “meet them where they are” engagement

Recognizing that justice involved adults often struggle to access traditional clinic based services, the county built in assertive outreach, community based engagement, and flexible service delivery to maintain contact and reduce missed opportunities for care.

• Whole person planning

Because justice involved adults frequently have trauma histories, co occurring disorders, and complex social needs, the county embedded natural support exploration, and whole person assessments into the FSP intake and treatment planning process.

• Focus on diversion, stabilization, and reducing deeper system involvement

Program design intentionally supports alternatives to incarceration, linkage to crisis care, stabilization in the community, and reduction of recidivism, jail days, and state hospital referrals.

• Cultural and linguistic responsiveness

The county ensured that FSP services reflect the cultural, linguistic, and community specific needs of justice involved adults, including access to interpreters, culturally specific engagement strategies, and partnerships with community based organizations serving diverse populations.

• Warm handoffs from crisis and justice settings

The county has in place warm handoffs from Crisis Services, the jail, courtrooms, and field based teams to ensure individuals at risk of justice involvement are quickly connected to FSP services.

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

The proposed model expands access to substance use services by strategically utilizing existing co-occurring outpatient field-based teams, Homeless Outreach teams and a field based Access to services team to deliver assertive, community-based interventions. These multidisciplinary teams already provide behavioral health services in community settings and are uniquely positioned to address substance use disorders (SUD) alongside co-occurring mental health conditions through proactive outreach and engagement.

Under this approach, field-based teams—including clinicians, case managers, peer support specialists, and substance use counselors—integrate assertive substance use services into their current outreach and treatment activities. Rather than relying solely on clinic-based encounters, staff meet individuals where they live, work, or gather, including homes, shelters, encampments, and other community settings. This approach reduces common barriers to treatment such as transportation challenges, stigma associated with clinic visits, and disengagement from traditional care systems.

The teams use an assertive engagement model that prioritizes relationship building, harm reduction, and

persistence in outreach efforts. Individuals with co-occurring mental health and substance use conditions often experience unstable housing, legal involvement, or repeated crisis service utilization. Field teams maintain consistent contact, offering flexible scheduling and frequent follow-ups to foster trust and encourage participation in treatment. Services may include screening and assessment for substance use disorders, motivational interviewing, relapse prevention counseling, medication support coordination, overdose prevention education, and linkage to higher levels of care when clinically indicated.

Integration with existing co-occurring outpatient services ensures that individuals receive coordinated and comprehensive care. Team members collaborate with psychiatrists, primary care and treatment providers, and community partners to address the full spectrum of client needs, including behavioral health treatment, medical care, housing support, and social services. Shared care planning and regular case conferencing help ensure that substance use treatment goals are aligned with mental health treatment plans and recovery objectives.

Peer support specialists play a critical role in engagement and recovery support. Drawing on lived experience, peers help reduce stigma, model recovery pathways, and assist clients in navigating treatment systems. Their involvement enhances the team's ability to connect with individuals who may be ambivalent about treatment or who have had negative experiences with traditional service systems.

By embedding assertive substance use services within existing field-based teams, the program maximizes available resources while expanding service capacity. This integrated approach improves continuity of care, increases treatment engagement, and reduces reliance on emergency departments, inpatient services, and criminal justice interventions. Ultimately, leveraging existing outpatient field-based teams allows the behavioral health system to provide timely, person-centered substance use services in the environments where individuals feel most comfortable and supported.

The County will utilize existing co-occurring, homeless and access to services outpatient field-based teams to implement Assertive Field-Based Substance Use Services (AFBSS) outreach for individuals with substance use disorders (SUD) and co-occurring mental health conditions who experience barriers to engaging in traditional clinic-based services. This strategy builds on the County's established infrastructure of multidisciplinary community-based teams to expand access to substance use services through proactive outreach and engagement in community settings.

Program descriptions

AFBSS outreach will be delivered by integrated field-based teams consisting of behavioral health clinicians, substance use counselors, case managers, and peer support specialists. These teams already provide services to individuals with complex behavioral health needs and are well-positioned to incorporate substance use screening, engagement, and brief intervention into their existing field-based work. By leveraging these teams, the County will increase its capacity to identify and engage individuals with untreated or undertreated substance use disorders while maintaining a coordinated approach to care for co-occurring conditions.

Outreach will occur in community locations where individuals naturally reside or gather, including homes, shelters, transitional housing programs, community centers, and other community-based settings. Teams

will also conduct outreach to individuals experiencing homelessness or those who have limited access to transportation or clinic-based services. The field-based model allows staff to meet individuals where they are, reducing barriers to treatment participation and promoting early engagement in substance use services.

AFBSS outreach will emphasize assertive engagement strategies that prioritize relationship-building, harm reduction, and ongoing contact with individuals who may be reluctant or unable to seek services independently. Staff will use evidence-informed practices such as motivational interviewing and trauma-informed engagement to support individuals in exploring readiness for change and identifying appropriate treatment options. Outreach activities may include screening for substance use disorders, brief interventions, overdose prevention education, distribution of harm reduction supplies when appropriate, and connection to medication-assisted treatment (MAT) and other treatment services.

Peer support specialists will play a key role in outreach and engagement efforts. Individuals with lived experience of recovery provide culturally responsive support, reduce stigma associated with treatment, and help build trust with community members who may be hesitant to engage with formal service systems. Peer support will also assist individuals in navigating services and maintaining connection to ongoing care.

Through AFBSS outreach, the County will strengthen coordination between substance use and mental health services by integrating screening, referral, and treatment planning across programs. Field-based teams will collaborate with medical providers, community organizations, housing programs, and other service systems to address the social and health needs that often contribute to substance use and treatment disengagement.

By leveraging existing co-occurring outpatient field-based teams to deliver AFBSS outreach, the County will expand early identification of substance use disorders, increase engagement among high-need populations, and improve access to timely and culturally responsive substance use services within the community.

Current funding source

MHSA/BHSA dollars, Drug-Medical, Dual Certified

BHSA changes to existing programs to meet BHSA requirements

Expansion and use of BHSA dollars for SUD services enhance ability to create programs that can be SUD only and fortify current outreach programs.

Expected timeline of operation

Targeted Outreach programs are already in place

Mobile-field based programs

Existing programs

As part of the Behavioral Health Services Act (BHSA) Integrated Plan and the County's implementation of Assertive Field-Based Substance Use Services (AFBSS), the County will partner with San Joaquin Health Clinics to expand the scope of existing mobile health services to include mobile Medication-Assisted Treatment (MAT) for individuals with substance use disorders (SUD). This partnership will strengthen access to low-barrier, community-based treatment and improve engagement for individuals who face significant barriers to traditional clinic-based care.

Currently, San Joaquin Health Clinics operates a mobile medical unit that provides primary care and preventive health services in community settings. Through this collaboration, the County will work with the organization to integrate substance use disorder treatment services into the mobile platform, enabling the delivery of medication-assisted treatment directly in the community. This expansion will allow individuals to receive screening, assessment, and medication initiation in locations that are accessible and familiar to them.

The mobile MAT unit will support individuals with opioid and alcohol use disorders through the provision of FDA-approved medications, including buprenorphine and naltrexone, when clinically appropriate. Services delivered through the mobile unit will include substance use screening and assessment, medication induction and maintenance, brief counseling interventions, overdose prevention education, and referral to additional behavioral health and social services. The mobile unit will also distribute harm reduction supplies and provide education related to overdose prevention and safer substance use practices.

Mobile MAT services will operate in coordination with the County's AFBSS outreach teams and other behavioral health programs. Field-based staff will identify individuals who may benefit from medication-assisted treatment and coordinate warm handoffs to the mobile unit during scheduled community visits. The mobile service model will prioritize outreach to communities with high rates of substance use disorders, individuals experiencing homelessness, and populations that have historically faced barriers to treatment engagement.

The mobile MAT unit will also strengthen integration between medical and behavioral health services by facilitating referrals to the County's outpatient substance use treatment programs, mental health services, and other supportive resources, including housing and case management services. Peer support specialists and outreach staff will assist individuals in navigating services and maintaining engagement in treatment following medication initiation.

By expanding the capabilities of an existing mobile medical unit to include medication-assisted treatment, the County will increase the availability of low-barrier substance use treatment services and extend care to individuals who may not otherwise access traditional treatment settings. This partnership supports the County's broader BHSA goals of improving access to treatment, reducing overdose risk, and delivering person-centered behavioral health services within community settings.

Program descriptions

SJ Health is committed to building a healthier community. One of its priorities is creating positive health outcomes by increasing access to care, providing additional resources, and strengthening community partnerships. Honoring its commitment, SJ Health established mobile health services to bridge gaps between people and health care providers.

Teams of providers, nurses, medical assistants and community health workers are deployed to locations where services are needed. Services include:

- Primary Care
- Chronic Disease Management
- Wound Care
- STD Testing and Treatment
- Women's Health
- Social Services and Health Education
- Addiction Medicine

SJ Health maintains a fleet of vehicles converted into one exam room clinics. They are scheduled to provide services at specific locations on a regular basis. No appointments needed.

In addition, Mobile Health Teams also do Walking Clinics (aka Backpack Clinics), mostly to serve patients who live in areas that can only be reached on foot. These include dry sloughs, encampments (tent or RV communities) by railroad tracks, open fields, and other areas where many people experiencing homelessness may live. Whenever possible, a mobile unit is used.

Street Medicine expands SJ Health's ability to serve the needs of a patient population that experiences more barriers to getting the medical care and non-clinical support they need. Non-clinical support may include obtaining identification or documentation, education about health topics, navigating services and appointments including transportation to medical appointments, referrals or support in getting housing and more. We are providers of Cal-AIM Enhanced Care Management and Community Supports.

Mobile Health Teams may also hold special clinics for testing, vaccination or health screenings at various locations such as community centers, schools, and other neighborhood hubs.

Special clinics for SJ Health patients may also be scheduled to help patients meet specific health care requirements. This may include chronic disease management screenings, well-child visits and vaccinations, enrollment requirements for students, and more.

SJ Health is committed to serving overall health goals for San Joaquin County and is actively engaged in coalitions and partnerships with other county agencies, health care systems and community-based organizations.

SJ Health is a member of the San Joaquin County Health Collaborative and leads the Binational Health Coalition.

SJ Health participates in community events, initiatives and activities. Community Health Workers can provide health education, health promotion, outreach and presentations to specific communities regarding relevant health topics.

Current funding source
SJ Health

BHSA changes to existing programs to meet BHSA requirements
SJ Health will offer MAT in the field along with existing medication services.

Expected timeline of operation
July 1, 2026

Open-access clinics

Existing programs
As part of the implementation of Assertive Field-Based Substance Use Services (AFBSS), the County will expand the capacity and accessibility of its existing Medication-Assisted Treatment (MAT) clinic by transitioning to an open access service model. This approach is designed to reduce barriers to treatment entry for individuals with substance use disorders (SUD), particularly those with co-occurring mental health conditions, individuals experiencing homelessness, and individuals who have historically struggled to engage in scheduled clinic-based care.
The current MAT clinic provides evidence-based treatment for opioid and alcohol use disorders through the use of FDA-approved medications, counseling, and case management services. Through the AFBSS initiative, the County will enhance this service by implementing an open access model that allows individuals to receive same-day or walk-in assessments and rapid initiation of medication-assisted treatment without the requirement of a scheduled appointment. This approach aligns with best practices for low-barrier treatment engagement and supports timely access to lifesaving medications.
Open access services will be integrated with the County's field-based outreach efforts. Assertive field-based teams conducting outreach through AFBSS will identify individuals in the community who may benefit from medication-assisted treatment and facilitate immediate linkage to the MAT clinic. When appropriate, outreach staff may accompany individuals to the clinic or coordinate same-day intake appointments to ensure rapid connection to care. This warm handoff process is intended to reduce drop-off between outreach contact and treatment initiation.
The expanded MAT clinic will provide comprehensive services including screening and assessment for substance use disorders, medication initiation and maintenance, clinical counseling, recovery support services, and coordination with behavioral health providers for individuals with co-occurring mental health conditions. Medications may include buprenorphine, naltrexone, and other clinically appropriate pharmacotherapies. The clinic will maintain a harm reduction and trauma-informed approach that supports individuals at various stages of readiness for change.
To support the open access model, the County will enhance staffing and workflow processes within the MAT clinic. Clinical staff, including medical providers, substance use counselors, and peer support specialists, will collaborate to provide rapid assessments, medication induction, and follow-up care. Peer

support specialists will assist individuals in navigating services, addressing stigma, and supporting ongoing engagement in treatment.

The integration of open access MAT services with AFBSS outreach will strengthen the County's continuum of care by ensuring that individuals encountered in community settings can access treatment quickly and without unnecessary delays. This approach is expected to increase treatment initiation rates, improve retention in medication-assisted treatment, and reduce overdose risk among individuals with opioid and alcohol use disorders.

Through the expansion of the existing MAT clinic into an open access model, the County will increase the accessibility, responsiveness, and effectiveness of its substance use treatment system while supporting the goals of the Behavioral Health Services Act (BHSA) to improve outcomes for individuals with complex behavioral health needs.

Program descriptions

The program is designed to transform traditional scheduled care into a "low-barrier" system by embedding external providers into established infrastructure:

• Contracted On-Site Providers: The county contracts with an MAT provider to staff the existing clinic.

• Open Access Framework: This partnership will allow the clinic to offer same-day assessments and treatment, meaning patients can walk in and receive medication immediately without a prior appointment.

• Asset Leveraging: By using an existing "brick and mortar" clinic, the program avoids the overhead of a new facility while adding the specialized staffing needed for rapid response.

Key Components to this program are:

• Integrated Care: Contracted providers work alongside county staff to ensure a whole-person approach, combining prescribing with counseling and case management.

• No Wrong Door: Members needing MAT cannot be denied services or required to taper off medications as a condition of entry.

• Rapid Initiation: The goal is to initiate FDA-approved medications at the point of first contact.

This model specifically targets high-risk individuals, including those experiencing homelessness in encampments or those recently released from justice involvement, who may not be able to adhere to traditional scheduled appointments.

Current funding source

Drug Medi-cal

BHSA changes to existing programs to meet BHSA requirements

Utilizing an existing clinic infrastructure and will embed low barrier open access model.

Expected timeline of operation
July 1, 2026

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

New programs
Utilizing our Co-occuring Outpatient Team to expand and build out the targeted outreach team. Utilize the homeless outreach team via the Whole Person Care Team to expand and enhance substance use targeted outreach. Access team will expand to field based and build out teams to provide services out in the field.

Program descriptions
Leveraging existing teams to expanded into a multi-team field-based operation.
This model shifts from traditional clinic-based care to a mobile, "street-to-treatment" approach, utilizing three specialized teams to reach the county's most vulnerable populations.
The first being the existing Homeless Outreach Team being enhanced specifically to address Substance Use Disorder (SUD) needs within encampments. This team acts as the primary point of contact for the unsheltered population. This team distributes harm reduction supplies, provides overdose prevention and education, and facilitates "warm handoffs" to MAT providers. This team works directly with the Co-Occurring and Access team to ensure that housing navigation is paired with clinical SUD treatment.
The existing Co-Occurring Team is responsible for the "build-out" of specialized outreach for individuals facing both mental health and substance use disorders. Their role is to identify and engage individuals with complex diagnoses who may be resistant to traditional office-based services. This team will not only work with existing members receiving co-occurring services, but will also provide clinical assessments in the field and initiates immediate MAT and mental health stabilizers before a formal clinic visit.
The Access Team is expanding from a centralized "triage and screening" function to a field-based "active engagement" unit. This team will follow up on referrals for services within the clinic but will expand outside the physical facility to ensure outreach, and linkage to programs and services.

Planned funding
MHSA/BHSA dollars, Drug-Medical, - Dual Certified

Planned operations
expansion and use BHSA dollars for SUD services enhances ability to create programs that can be SUD only and fortify current Co-occuring programs.

Expected timeline of implementation
July 1, 2026

Mobile-field based programs

New programs
Mobile Medication Clinic will add Mobile MAT Clinic through SJ Clinic - Contracted and being built out this fiscal year.

Program descriptions
The program is designed to transform traditional scheduled care into a "low-barrier" system by embedding external providers into established infrastructure:
• Contracted On-Site Providers: The county contracts with an MAT provider to staff the existing clinic.
• Open Access Framework: This partnership will allow the clinic to offer same-day assessments and treatment, meaning patients can walk in and receive medication immediately without a prior appointment.
• Asset Leveraging: By using an existing "brick and mortar" clinic, the program avoids the overhead of a new facility while adding the specialized staffing needed for rapid response.
Key Components to this program are:
• Integrated Care: Contracted providers work alongside county staff to ensure a whole-person approach, combining prescribing with counseling and case management.
• No Wrong Door: Members needing MAT cannot be denied services or required to taper off medications as a condition of entry.
• Rapid Initiation: The goal is to initiate FDA-approved medications at the point of first contact.
This model specifically targets high-risk individuals, including those experiencing homelessness in encampments or those recently released from justice involvement, who may not be able to adhere to traditional scheduled appointments.

Planned funding
expansion and use BHSA dollars for SUD services enhances ability to create programs that can be SUD only and fortify current Co-occuring programs.

Planned operations
Mobile Medication Clinic will add Mobile MAT Clinic through SJ Clinic - Contracted and being built out this fiscal year.

Expected timeline of implementation
July 1, 2026

Open-access clinics

New programs
MAT Clinic at our Railroad Square site. Psych meds and MAT medications - Open Scheduling to take walk-ins

Program descriptions
As part of the implementation of Assertive Field-Based Substance Use Services (AFBSS), the County will expand the capacity and accessibility of its existing Medication-Assisted Treatment (MAT) clinic by transitioning to an open access service model. This approach is designed to reduce barriers to treatment entry for individuals with substance use disorders (SUD), particularly those with co-occurring mental health conditions, individuals experiencing homelessness, and individuals who have historically struggled to engage in scheduled clinic-based care.
The current MAT clinic provides evidence-based treatment for opioid and alcohol use disorders through the use of FDA-approved medications, counseling, and case management services. Through the AFBSS initiative, the County will enhance this service by implementing an open access model that allows individuals to receive same-day or walk-in assessments and rapid initiation of medication-assisted treatment without the requirement of a scheduled appointment. This approach aligns with best practices for low-barrier treatment engagement and supports timely access to lifesaving medications.
Open access services will be integrated with the County's field-based outreach efforts. Assertive field-based teams conducting outreach through AFBSS will identify individuals in the community who may benefit from medication-assisted treatment and facilitate immediate linkage to the MAT clinic. When appropriate, outreach staff may accompany individuals to the clinic or coordinate same-day intake appointments to ensure rapid connection to care. This warm handoff process is intended to reduce drop-off between outreach contact and treatment initiation.
The expanded MAT clinic will provide comprehensive services including screening and assessment for substance use disorders, medication initiation and maintenance, clinical counseling, recovery support services, and coordination with behavioral health providers for individuals with co-occurring mental health conditions. Medications may include buprenorphine, naltrexone, and other clinically appropriate pharmacotherapies. The clinic will maintain a harm reduction and trauma-informed approach that supports individuals at various stages of readiness for change.
To support the open access model, the County will enhance staffing and workflow processes within the MAT clinic. Clinical staff, including medical providers, substance use counselors, and peer support specialists, will collaborate to provide rapid assessments, medication induction, and follow-up care. Peer support specialists will assist individuals in navigating services, addressing stigma, and supporting ongoing engagement in treatment.

The integration of open access MAT services with AFBSS outreach will strengthen the County's continuum of care by ensuring that individuals encountered in community settings can access treatment quickly and without unnecessary delays. This approach is expected to increase treatment initiation rates, improve retention in medication-assisted treatment, and reduce overdose risk among individuals with opioid and alcohol use disorders.
Through the expansion of the existing MAT clinic into an open access model, the County will increase the accessibility, responsiveness, and effectiveness of its substance use treatment system while supporting the goals of the Behavioral Health Services Act (BHSA) to improve outcomes for individuals with complex behavioral health needs.

Planned funding
Drug Medical and Medical

Planned operations
The program is designed to transform traditional scheduled care into a "low-barrier" system by embedding external providers into established infrastructure:
• Contracted On-Site Providers: The county contracts with an MAT provider to staff the existing clinic.
• Open Access Framework: This partnership will allow the clinic to offer same-day assessments and treatment, meaning patients can walk in and receive medication immediately without a prior appointment.
• Asset Leveraging: By using an existing "brick and mortar" clinic, the program avoids the overhead of a new facility while adding the specialized staffing needed for rapid response.
Key Components to this program are:
• Integrated Care: Contracted providers work alongside county staff to ensure a whole-person approach, combining prescribing with counseling and case management.
• No Wrong Door: Members needing MAT cannot be denied services or required to taper off medications as a condition of entry.
• Rapid Initiation: The goal is to initiate FDA-approved medications at the point of first contact.
This model specifically targets high-risk individuals, including those experiencing homelessness in encampments or those recently released from justice involvement, who may not be able to adhere to traditional scheduled appointments.

Expected timeline of implementation
July 1, 2026

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

As part of the Behavioral Health Services Act (BHSA) Integrated Plan and implementation of Assertive Field-Based Substance Use Services (AFBSS), the County will conduct a comprehensive assessment to identify gaps between existing Medication-Assisted Treatment (MAT) resources and the level of services needed to meet the needs of the County's population. This assessment will inform strategic expansion of MAT access and ensure that services are aligned with community needs, particularly for populations experiencing barriers to treatment engagement.

The County will begin by conducting a baseline analysis of current MAT capacity, including the number and geographic distribution of MAT providers, clinic locations, prescriber availability, service hours, and the types of medications offered for opioid and alcohol use disorders. This review will include services provided by the County behavioral health system, contracted providers, Federally Qualified Health Centers, hospitals, and community-based treatment programs. The analysis will also examine existing wait times for MAT services, appointment availability, and utilization patterns to determine whether current capacity meets demand.

In addition to evaluating existing services, the County will analyze population-level data to estimate treatment need. Data sources may include overdose and substance-related mortality data, emergency department visits related to substance use, hospitalizations, law enforcement and public health reports, and behavioral health service utilization data. The County will also review data related to high-risk populations, including individuals experiencing homelessness, justice-involved individuals, and individuals with co-occurring mental health conditions who may benefit from MAT but are not currently receiving treatment.

The County will further assess service gaps through community and stakeholder engagement, including consultation with community-based organizations, healthcare providers, peer support organizations, individuals with lived experience, and other key partners involved in substance use prevention and treatment. Feedback from these stakeholders will help identify barriers to accessing MAT services, such as transportation challenges, stigma, limited-service hours, language barriers, or lack of culturally responsive services. We can utilize past satisfaction surveys.

Findings from this assessment will be used to identify priority areas for system improvement and resource expansion. This may include increasing the number of MAT prescribers, expanding clinic hours, implementing open-access or same-day medication models, strengthening partnerships with community health providers, and deploying mobile treatment services to underserved areas. The County will also evaluate opportunities to integrate MAT access within AFBSS outreach efforts to improve engagement among individuals who are not currently connected to care.

The County will continue to monitor MAT capacity and population need on an ongoing basis through routine data review and program evaluation. Performance indicators such as treatment initiation rates, retention in medication-assisted treatment, geographic access to services, and reductions in overdose events will be used to assess whether expanded MAT services are effectively addressing identified gaps. Through this data-informed approach, the County aims to ensure that MAT resources are responsive to the evolving needs of the community and that individuals experiencing substance use disorders have timely

access to evidence-based treatment through the AFBSS service continuum.

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

Contract directly with MAT providers in the County
Operate MAT clinics directly
Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
Leverage telehealth model(s)
Contract with MAT providers in other counties

Please provide the names of other counties the contracted MAT providers are located in

Stanislaus, Sacramento,

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

Naltrexone
Methadone
Buprenorphine

Housing Interventions

Planning

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

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting

and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) **to inform responses to this question.**

Supportive housing
Small gap

Apartments, including master-lease apartments
Small gap

Single and multi-family homes
Not applicable

Housing in mobile home communities
Not applicable

(Permanent) Single room occupancy units
Medium gap

(Interim) Single room occupancy units
Small gap

Accessory dwelling units, including junior accessory dwelling units
Not applicable

(Permanent) Tiny homes
Medium gap

Shared housing
Small gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Not applicable

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

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

License-exempt room and board
Not applicable

Hotel and Motel stays
Small gap

Non-congregate interim housing models
Not applicable

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
Medium gap

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

Peer Respite
Small gap

Permanent rental subsidies
Not applicable

Housing supportive services
Small 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 **?**
County Partnerships, MOU's with room and boards, landlords, contracts with CBO's providing housing. We will utilize HHAP funding, BHBH funding and MCP funding to bolster funding resources to expand supply and increase access to housing. Opioid Settlement Funds (OSF) will be leveraged for the County's "BE WELL" Campus to also increase capacity.

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?
1. It will expand portfolio of housing that is not connected to treatment, expand self sufficiency and help get connected to community which is a goal of the homeless and housing continuum.
2. HHAP and other funding sources helps us leverage state funding for infrastructure and rental support and transitional housing.
3. OSF will allow us to be creative with different housing solutions for those that are homeless or at risk of homelessness during their recovery.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
Housing members have a very low eviction rate and are matched to the correct housing intervention to meet successful housing placement and retention. Continuing to provide wraparound services to sustain and support placements, i.e. housing skills, self-advocacy.

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)?
1. Partnership with the local Housing Authority
2. Landlord Acquisition
3. Building partnerships with property management and education about members needs.
4. Continued fiscal partnership with the local Housing Authority.

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

All housing settings have a dedicated housing clinical team made up of case managers which include clinicians, outreach workers and peer support specialists. In addition, members are connected to employment services and other resources as needed. FY 2025-26 BHS created a new division to expand and enhance support services for our unhoused and housed members to fortify a strong organizational approach for our housing continuum.

Eligible Populations

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

BHSA HI eligible members will be identified through the Cal-Aim domain based assessment which identifies if a member meets BHSA eligibility and their housing status. Once a member has been identified the member will be screened by their BHS case manager to determine if they are homeless or at risk of homelessness. Once screened the member will be linked to the Housing for Health division to determine what housing resource is needed which includes the BHSA HI, Transitional Rent, and BHBH funding sources. If the member is seeking interim housing they will be linked to BHSA HI dollars after MCP dollars have been exhausted or deemed not available. If a member is seeking permanent housing a member will be linked to a housing project that is funded by BHSA HI or receive rental support per our internal BHSA policy and procedures.

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

The County Children and Youth Division continuously engages with leadership and eligibles of the probation department through ongoing meetings throughout the year to inform needs related to all BHSA services.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
The County Children and Youth Division continuously engages with families and youth of the LGBTQ+ community to uplift unique need that the LGBTQ+ eligibles to inform needs related to all BHSA services.

In the child welfare system
The County Children and Youth Division continuously engages with leadership and eligibles of the child welfare department through ongoing meetings throughout the year to inform needs related to all BHSA services.

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
For our older adult population, the county assessed common barriers with accessing housing, researched patterns in homelessness based on the 2022-2024 PIT count and identified what supportive services are needed for this population to maintain housing. In addition, the county worked with the Older Adult Team that has provided information on what this population needs such as in home support services, community focused housing, and ADA accessible housing options.

In, or are at risk of being in, the justice system
For our justice involved population we worked with our Justice Community Integration Department to identify what housing solutions are needed for this population. Through stakeholder engagement we were able to identify immediate low barrier housing options after release prevents the risk of recidivism. In addition, we have partnered with the local housing authority to provide permanent housing options that allow for members with a criminal background to have a second chance at stable housing. Through systematic partnerships with Correctional Health, Probation, and the local court system the county was able to identify and create creative housing solutions for this population.

In underserved communities
The county has worked with the Local Pride Center to identify gaps in services and housing for the LGTBTQ+ population. Through stakeholder engagement we learned that having individual room options support members who are transitioning or may not feel comfortable in same sex rooms with a gender they don't identify with. Also, having single room options provide a safe space for that individual versus being in a lodge or congregate housing setting.

Local Housing System Engagement

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

The Deputy Director of Housing for Health is a board member and actively participates in the CoC committee meetings. This year the Deputy Director was the committee chair for the 2024-2026 PIT count which demonstrates the integration of behavioral health into our Local CoC homeless initiatives. The Deputy Director works directly with HMIS lead on BHSA HMIS implementation and the HMIS lead is also the Flex Pool Operator for the SJC Flex Pool. The HMIS lead is embedded in many of the county functions and directly linked to the BHSA HI projects which is overseen by the Housing for Health Division. In working with HMIS lead the Deputy Director has created a workflow that when MHSA/BHSA eligible members utilize interim settings they are automatically put into the coordinated entry system. The partnership with the coordinated entry lead is strengthened since this organization and behavioral health services are both under SJC Health Care Services.

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

Deputy Director of Housing for Health is a board member of the local COC. Continuous engagement with COC members and strong partnership with HMIS lead, and relationship with coordinated entry system lead.

Public Housing Agency

Partnership with Housing Authority of San Joaquin County - The county currently has six permanent supportive housing projects with the Public Housing that solely provides housing for MHSA/BHSA eligible individuals. There are three more projects that have been scheduled for groundbreaking which expands our permanent housing portfolio. The County's approach with Public Housing is creation and innovation when developing new projects that can support BHSA eligible population.

MCPs

The county is contracted with HealthNet and Health Plan of San Joaquin as a transitional rent and housing deposit provider; and with Kaiser as a transitional Rent Provider. The county's approach to the partnership with the MCP's is that collaboration, communication, and a community approach is key. We work with the MCP's to problem solve any issues that arise as a community supports provider and we ensure that we are aligning workflows with new BHSA HI policies to ensure members get linked to housing benefits as needed.

ECM and Community Supports Providers
BHS is a community supports provider for Transitional rent deposits and work with other partner departments under the San Joaquin County Health Care Services Agency, i.e. SJHEALTH (ECM and community supports), WHOLE PERSON CARE (ECM team for correctional health).

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

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?
Bridge to Home (transitional housing until 2027) and becoming permanent supportive housing thereafter with 64 units. The Bridge to Home project is a partnership between Central Valley Low Income Housing Inc and County Behavioral Health Services. This project was created from HomeKey + grant funding and Behavioral Health Bridge Housing grant funding. This housing project will serve as permanent housing for BHSA eligible individuals which include on site services provided Housing for Health case management team and integrate community resources such as food bank delivery, on site peer support groups, and other identified resources. As mentioned with our process for identifying, screening, and linking individuals to BHSA HI projects. Members will be referred to this project once identified and screened.

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?
150

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
64

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
86

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
The method elected for calculating rental subsidies will be based on Fair Market rents (FMR's)

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Time Limited Interim Settings: Hotel and motel stays
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: 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
For interim settings funded by BHSA HI members will have 30% participant contribution for 6-12 months which depends if the member has exhausted transitional rent benefit. For permanent settings members will pay 30% participant contribution for up to 6 months with the goal for members to self-pay or transition to a BHS apartment that is subsidized or has a voucher.

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

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
SJCBHS has a robust continuum which includes transitional housing and permanent housing partnered with the Housing Authority, Central Valley Low Income Housing Inc, and local landlords within San Joaquin County. BHS will continue to build our housing options through landlord acquisition, the flex pool, utilizing the HMIS system and community que, and the future projects with the housing authority. SJCBHS just completed a request for qualifications for housing developers as we expand housing options under BHSA. SJCBHS will utilize the following companies in new housing projects: Central Valley Low Income Housing Corporation; Delta Community Developers Corporation; Domus Development LLC; Mahogany & Oak Real Estate; Mutual Housing California; RHCB Development LP; Self-Help Enterprises; and Visionary Home Builders of California Inc

Total number of units funded with BHSA Housing Interventions per year
350

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
116

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

We currently operate SRO and Transitional to Perm apartments and congregate room and board. Operating subsidies are used for property management staff.

For which setting types will the county provide operating subsidies?

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: Other settings identified under the Transitional Rent benefit
Non-Time-Limited Permanent Settings: Supportive housing

Will this be a scattered site initiative?

Yes

Will this Housing Intervention accommodate family housing?

Yes

Total number of units funded with BHSA Housing Interventions per year

228

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

100

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

The county anticipates the following activities to be performed to outreach landlords: Hosting community Q&A sessions to educate landlords about BHSA and Housing Intervention funds, Request for proposals to acquire property for new projects, and inviting landlords to participate in local CoC meetings. The county anticipates the following activities to be performed to maintain landlord relationships: bi-weekly/monthly meetings to discuss tenants, issues, and areas of improvements, training to educate landlords on population and supportive services, and utilizing landlord mitigation funds to manage any damages that tenants create during tenancy.

Total number of units funded with BHSA Housing Interventions per year

150

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

150

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

Members who are not eligible for MCP housing deposits which include housing goods would be eligible for participant funds to support housing setup and can be used to reduce barriers to access to housing.

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

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select**

Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
Members will be referred to the MCP to receive these services

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

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
Outreach and engagement is being provided through the BHSS component related to housing needs through Early Intervention in the Whole Person Care Project.

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
Tiny Homes Project

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

Capacity (Anticipated number of individuals housed at a given time)
50

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
50

Total number of units funded with Housing Interventions funds only
0

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)
6/30/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
450000

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

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
Edison House

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Single room occupancy units

Capacity (Anticipated number of individuals housed at a given time)
33

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
33

Total number of units funded with Housing Interventions funds only
0

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)
6/30/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
450000

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

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

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Behavioral Health Bridge Housing and MCP Dollars.

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?
Transitional Rent
Housing Deposits

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

Housing Transition Navigation Services
No

Housing Deposits
Yes

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

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

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

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs **(including Transitional Rent)?**
The county has created an internal referral system with MCP's so they can refer members to the county who can benefit from the housing- related community supports. Once the county has established BHSA eligibility then the county submits an authorization request to the MCP's for approval. The county leverages BHBH or BHSA funding for the member until authorization is approved by the MCP's. The county has identified dedicated liaisons with MCP's to answer any questions, trouble shoot problems and discuss how workflows can be streamlined to ensure limited member disruption when being connected to services.

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

In addition to the contracts, MOUs, and collaborative meetings with MCP's. The county has created an internal referral system with MCP's so they can refer members to the county who can benefit from the housing- related community supports. Once the county has established BHSA eligibility then the county submits an authorization request to the MCP's for approval. The county leverages BHBH or BHSA funding for the member until authorization is approved by the MCP's. The county has identified dedicated liaisons with MCP's to answer any questions; trouble shoot problems and discuss how workflows can be streamlined to ensure limited member disruption when being connected to services.

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

No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

Prior to a member getting connected to MCP's housing related community supports the county completes a housing assessment and housing support plan which identifies goals and gaps in maintaining housing. The county leverages BHSA housing intervention funds to support members in an interim setting for 6 months so the member has 12 months of housing with the goal to link to permanent housing. The county has adopted a Flex Pool model to help braid funds and so members are not impacted by changing funding streams.

Flexible Housing Subsidy Pools

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

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

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

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

What role does the county behavioral health system have or plan to have in the Flex Pool?
Lead Entity
Funder

What organization is serving as the Operator?
Central Valley Low Income Housing

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

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies
Operating Subsidies
Capital Development Projects

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
The County is participating in the T.A. Flex Pool Academy by DHCS. One of 13 counties selected to participate in the program.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

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

No

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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

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

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

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

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

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

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
13

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

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

Please describe any other key workforce gaps in the county
No other workforce gaps outside of the five positions mentioned above.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?
The implementation of EBP's for the diverse workforce will be addressed with working with COE's and evidence-based experts in the field to train and enhance current and new staff needed to run these

programs to fidelity. BHS Managers will lead the efforts in revamping teams (hiring and/or shifting staff) to meet the BHT and BH-Connect program requirements.

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
The County will continue to engage staff, contractors, and community members related to BH-Connect workforce programs administered HCAI by promoting and marketing these efforts via email campaign to all interested parties.

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
The County will continue to engage staff, contractors, and community members related to BH-Connect workforce programs administered HCAI by promoting and marketing these efforts via email campaign to all interested parties.

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
SJCBHS will leverage this funding for the following:
Support supervision hours of pre-licensure or pre-certification practitioners
Cover Backfill costs to support Behavioral Health Practictioners receiving training in EBPs
Covering the costs of initial certification and licensing fees. Prioritizing Substance abuse counselors and PSSCs

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

Please explain any actions or activities the county is engaging in to leverage the program
The County will continue to engage staff, contractors, and community members related to BH-Connect workforce programs administered HCAI by promoting and marketing these efforts via email campaign to all interested parties.

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

Please explain any actions or activities the county is engaging in to leverage the program
The county will consider applying for future fund fellowships for Child and Adolescent Psychiatry, Addiction Psychiatry, and Addiction Medicine, if appropriate

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
The county has recently been successful in solving through meaningful strategies to improve workforce shortage. Our strong partnership with HealthForce Partners reduced vacancy 61-70%, cut clinician caseloads by 59% and coverted 81% of interns by Year 2. We were able to successfully meet this challenge by:

1. Internship and Practicum expansion - Collaborating with Stanislaus State and University of the Pacific, to increase local training opportunities.
2. Supervision Capacity Building - HealthForce Partners provided intern supervision on behalf of employers increasing placement capacity and expanding access to care.
3. Targeted Financial Incentives - Stipends, retention bonuses, and scholarships addressed immediate financial barriers to participation.

4. Backbone Coordination Model - HealthForce Partners convened education institutions, clinical sites, funders, and county agencies, aligning goals and managing implementation.
5. "Grow Our Own" strategy - Prioritized local talent, upskilling existing residents and current employees through accessible pathways to advanced degrees and licensure.
6. Regional Expansion Planning - Active discussions with Stanislaus and Merced counties aim to establish a centralized regional clinical placement model, broadening impact.

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
SJC Integrated-Plan-Budget-Template_v3 7-21-26.xlsx

Please upload supporting data

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)
The county plans to cover the costs of BHSS related programming from the prudent reserve excess to fortify programs that may have been reduced or eliminated due to component funding reduction.

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

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

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

BHSS
The draw down of excess prudent reserve funds into the BHSS component aligns with maintaining BHSS core programs that provide Wellness and Peer programs, Crisis Expansion Services and treatment services for TAY and Justice Involved beneficiaries

FSP
N/A

Housing Interventions
N/A

Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 23,449,511.00	$ 23,684,006.00	$ 23,920,846.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 23,449,511.00	$ 23,684,006.00	$ 23,920,846.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 1,399,234.00	$ 1,413,226.00	$ 1,813,316.00	$ 899,248.00	$ 908,240.00	$ 917,322.00	$ 105,600.00	$ 106,656.00	$ 107,723.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 387,306.00	$ 391,179.00	$ 395,091.00	$ 1,574,328.00	$ 1,590,071.00	$ 1,605,972.00	$ 60,400.00	$ 61,004.00	$ 61,614.00
FSP Intensive Case Management	$ 18,351,651.00	$ 18,535,168.00	$ 18,720,519.00	$ 16,054,000.00	$ 16,214,540.00	$ 16,376,685.00	$ 1,096,890.00	$ 1,107,859.00	$ 1,118,938.00
High Fidelity Wraparound	$ 247,500.00	$ 505,000.00	$ 510,050.00	$ 250,000.00	$ -	$ -	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 210,972.00	$ 213,082.00	$ 215,212.00	$ 100,000.00	$ 101,000.00	$ 102,000.00	$ 1,000.00	$ 1,010.00	$ 1,020.00
Assertive Field-Based Initiation for SUD Treatment Services	$ 110,050.00	$ 110,050.00	$ 110,050.00	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 5,000.00	$ 5,000.00	$ 5,000.00
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ 443,637.00	$ 449,174.00	$ 454,766.00	$ 350,000.00	$ 353,500.00	$ 357,035.00	$ 47,587.00	$ 48,063.00	$ 48,544.00
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 21,150,350.00	$ 21,616,879.00	$ 22,219,004.00	$ 19,327,576.00	$ 19,267,351.00	$ 19,459,014.00	$ 1,316,477.00	$ 1,329,592.00	$ 1,342,839.00
FSP Transfer Information	**Year One**	**Year Two**	**Year Three**						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**						
FSP Component Admin Expenses	$ 2,299,161.00	$ 2,067,127.00	$ 1,701,842.00						
Total Full Service Partnership Expenditures (auto-populated)	$ 23,449,511.00	$ 23,684,006.00	$ 23,920,846.00						
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**						
Eligible Children/TAY (25 years and younger)	350	355	360						
Eligible Adults/Older Adults	450	460	470						
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**						
MHSA "Encumbered" INN	$ -	$ -	$ -						

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

Instructions

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

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.

Row 139: the total transferred excess prudent reserve is auto-populated.

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

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 20,099,581.00	$ 23,449,511.00	$ 20,099,581.00	$ 63,648,673.00
Year Two Component Allocation (dollars)	$ 20,300,577.00	$ 23,684,006.00	$ 20,300,577.00	$ 64,285,160.00
Year Three Component Allocation (dollars)	$ 20,503,583.00	$ 23,920,846.00	$ 20,503,583.00	$ 64,928,012.00

BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	35%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 15,409,678.77	$ 23,449,511.00	$ 24,119,497.20	$ 62,978,686.97
Unspent Mental Health Services Act (MHSA) to BHSA	$ 21,383,458.00	$ -	$ 26,568,836.00	$ 47,952,294.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	35%	42%	100%

Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 15,563,775.70	$ 23,684,006.00	$ 24,360,692.40	$ 63,608,474.10

BHSA Transfers
Year Three Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	35%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 15,719,413.63	$ 23,920,846.00	$ 24,604,299.60	$ 64,244,559.23

Funding Transfer Request Allocations

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

Base Component (Year One)	Housing Intervention Percentage (Year One)	Housing Intervention Funds (Year One)
Base Percentage and Funding	30%	$ 20,099,581.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 20,099,581.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 23,449,511.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 23,449,511.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 20,099,581.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 20,099,581.00

Funding Transfers (Year One)

	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	7%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	23%	35%	42%	Row Equals 100%

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

Base Component (Year Two)	Housing Intervention Percentage (Year Two)	Housing Intervention Funds (Year Two)
Base Percentage and Funding	30%	$ 20,300,577.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 20,300,577.00

Transferred To/From	Full Service Partnership Percentage (Year Two)	Full Service Partnership Funds (Year Two)
Base Percentage and Funding	35%	$ 23,684,006.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 23,684,006.00

Transferred To/From	Behavioral Health Services and Support Percentage (Year Two)	Behavioral Health Services and Support Funding (Year Two)
Base Percentage and Funding	35%	$ 20,300,577.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 20,300,577.00

Funding Transfers (Year Two)

	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	-7%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	23%	35%	42%	Row Equals 100%

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

Base Component	Housing Intervention Percentage (Year Three)	Housing Intervention Funds (Year Three)
Base Percentage and Funding	30%	$ 20,503,583.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 20,503,583.00

Transferred To/From	Full Service Partnership Percentage (Year Three)	Full Service Partnership Funds (Year Three)
Base Percentage and Funding	35%	$ 23,920,846.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 23,920,846.00

Transferred To/From	Behavioral Health Services and Support Percentage (Year Three)	Behavioral Health Services and Support Funding (Year Three)
Base Percentage and Funding	35%	$ 20,503,583.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 20,503,583.00

Funding Transfers (Year Three)

	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	-7%	Transfers Out and In Equal

New Base Percentage after Funding Transfer Request (auto-populated)	23%	35%	42%	Row Equals 100%

MHSA Transfers to BHSA

MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 30,000,000.00	$ 21,383,458.00	$ -	$ 8,616,542.00
PEI	$ 5,000,000.00	$ -	$ -	$ 5,000,000.00
Encumbered INN	$ -	$ -	$ -	$ -
Unencumbered INN	$ 8,352,294.00	$ -	$ -	$ 8,352,294.00
WET	$ 600,000.00			$ 600,000.00
CFTN	$ 4,000,000.00			$ 4,000,000.00
Total (auto-populated)	$ 47,952,294.00	$ 21,383,458.00	$ -	$ 26,568,836.00

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 6,939,866.00
Local Prudent Reserve Maximum (2)	$ 11,070,813.04
Excess Prudent Reserve Funding that must be transferred	**$ (4,130,947.04)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

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

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

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

Instructions

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

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

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

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

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

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

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

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

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

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 1,272,973.00	$ 1,285,703.00	$ 1,298,560.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 3,182,433.00	$ 3,214,257.00	$ 3,246,400.00
New and Ongoing Administrative Costs	$ 8,351,330.00	$ 11,494,388.00	$ 10,954,017.00
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 63,648,672.00	$ 64,285,159.00	$ 64,928,011.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2.0%	2.0%	2.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	5.0%	5.0%	5.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**
References			

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

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

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

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

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	23%	35%	42%	100%
Component Allocations	$ 15,409,678.00	$ 23,449,511.00	$ 24,119,497.00	$ 62,978,686.00
Year Two				
Allocation Percentage, with Transfers	23%	35%	42%	100%
Component Allocations	$ 15,563,775.00	$ 23,684,006.00	$ 24,360,692.00	$ 63,608,473.00
Year Three				
Allocation Percentage, with Transfers	23%	35%	42%	100%
Component Allocations	$ 15,719,413.00	$ 23,920,846.00	$ 24,604,299.00	$ 64,244,558.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	Full Service Partnerships (Year One)	Behavioral Health Services and Supports (Year One)	Year One Totals

Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 15,409,678.00	$ 23,449,511.00	$ 24,119,497.00	$ 62,978,686.00
Transfers From PR Into Component	$ -	$ -	$ 2,164,989.00	$ 2,164,989.00
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ -	$ 8,856,279.00	$ 8,856,279.00
Estimated Total Available Funding for Year One	$ 15,409,678.00	$ 23,449,511.00	$ 35,140,765.00	$ 73,999,954.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 15,409,678.00	$ 23,449,511.00	$ 35,140,765.00	$ 73,999,954.00

BHSA Funding Summary (Year Two)

	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 15,563,775.00	$ 23,684,006.00	$ 24,360,692.00	$ 63,608,473.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 10,691,729.00	$ -	$ 8,856,279.00	$ 19,548,008.00
Estimated Total Available Funding for Year Two	$ 26,255,504.00	$ 23,684,006.00	$ 33,216,971.00	$ 83,156,481.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 26,255,504.00	$ 23,684,006.00	$ 33,126,971.00	$ 83,066,481.00

BHSA Funding Summary (Year Three)

	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 15,719,413.00	$ 23,920,846.00	$ 24,604,299.00	$ 64,244,558.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 10,691,729.00	$ -	$ 8,946,279.00	$ 19,638,008.00
Estimated Total Available Funding for Year Three	$ 26,411,142.00	$ 23,920,846.00	$ 33,550,578.00	$ 83,882,566.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -

Estimated Total Year Three Expenditures	$ 26,411,142.00	$ 23,920,846.00	$ 33,460,578.00	$ 83,792,566.00

BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$ 1,272,973.00	$ 1,285,703.00	$ 1,298,560.00	$ 3,857,236.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 3,182,433.00	$ 3,214,257.00	$ 3,246,400.00	$ 9,643,090.00
Total Projected New and Ongoing Administrative Expenditures	$ 8,351,330.00	$ 11,494,388.00	$ 10,954,017.00	$ 30,799,735.00

Instructions

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

Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.

Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here. Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.

Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.

Row 45: input expenditures for BHSA-funded innovation pilots or projects.

Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.

Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.

Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.

Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).

Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.

Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.

Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.

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

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 24,119,497.00	$ 24,360,692.00	$ 24,604,299.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ 2,164,989.00	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 8,856,279.00	$ 8,856,279.00	$ 8,856,279.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 35,140,765.00	$ 33,216,971.00	$ 33,460,578.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 4,529,128.00	$ 4,529,128.00	$ 4,529,128.00	$ 3,616,458.00	$ 3,652,623.00	$ 3,689,149.00	$ 187,837.00	$ 189,715.00	$ 187,346.00
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 6,299,315.00	$ 6,299,315.00	$ 6,299,315.00	$ 5,029,933.00	$ 5,080,232.00	$ 5,131,065.00	$ 261,525.00	$ 257,989.00	$ 260,569.00
Early Intervention Expenditures	$ 16,167,314.00	$ 16,167,314.00	$ 16,167,314.00	$ 13,220,212.00	$ 13,352,414.00	$ 13,485,938.00	$ 1,011,992.00	$ 1,022,112.00	$ 1,032,334.00
Coordinated Specialty Care for First Episode Psychosis	$ 63,045.00	$ 63,045.00	$ 63,045.00	$ 1,602,823.00	$ 1,618,851.00	$ 1,635,040.00	$ 180,500.00	$ 182,305.00	$ 184,128.00
All Other EI Expenditures	$ 16,104,269.00	$ 16,104,269.00	$ 16,104,269.00	$ 11,617,389.00	$ 11,733,563.00	$ 11,850,898.00	$ 831,492.00	$ 839,807.00	$ 848,206.00
Outreach and Engagement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 1,028,074.00	$ 1,028,074.00	$ 1,028,074.00	$ -	$ -	$ -	$ -	$ -	$ -

Dedicated BHSA WET funds	$ 1,028,074.00	$ 1,028,074.00	$ 1,028,074.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 5,000,000.00	$ 3,000,000.00	$ 3,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ 5,000,000.00	$ 3,000,000.00	$ 3,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 33,023,831.00	$ 31,023,831.00	$ 31,023,831.00	$ 21,866,603.00	$ 22,085,269.00	$ 22,306,152.00	$ 1,461,354.00	$ 1,469,816.00	$ 1,480,249.00

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 2,116,934.00	$ 2,103,140.00	$ 2,436,747.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 35,140,765.00	$ 33,126,971.00	$ 33,460,578.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 14,467,779.00	$ 14,467,779.00	$ 14,467,779.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	52.9%	56.5%	56.0%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	89.5%	89.5%	89.5%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	183	183	183
Eligible Adults/Older Adults	4371	4371	4371
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ 1,028,074.00	$ 1,028,074.00	$ 1,028,074.00
BHSS transfer to CF/TN	$ 5,000,000.00	$ 3,000,000.00	$ 3,000,000.00
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ 600,000.00	$ 600,000.00	$ 600,000.00
Estimated MHSA CF/TN Funds	$ 4,000,000.00	$ 4,000,000.00	$ 4,000,000.00
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).

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

Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 23,449,511.00	$ 23,684,006.00	$ 23,920,846.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 23,449,511.00	$ 23,684,006.00	$ 23,920,846.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 1,399,234.00	$ 1,413,226.00	$ 1,813,316.00	$ 899,248.00	$ 908,240.00	$ 917,322.00	$ 105,600.00	$ 106,656.00	$ 107,723.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 387,306.00	$ 391,179.00	$ 395,091.00	$ 1,574,328.00	$ 1,590,071.00	$ 1,605,972.00	$ 60,400.00	$ 61,004.00	$ 61,614.00
FSP Intensive Case Management	$ 18,351,651.00	$ 18,535,168.00	$ 18,720,519.00	$ 16,054,000.00	$ 16,214,540.00	$ 16,376,685.00	$ 1,096,890.00	$ 1,107,859.00	$ 1,118,938.00
High Fidelity Wraparound	$ 247,500.00	$ 505,000.00	$ 510,050.00	$ 250,000.00	$ -	$ -	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 210,972.00	$ 213,082.00	$ 215,212.00	$ 100,000.00	$ 101,000.00	$ 102,000.00	$ 1,000.00	$ 1,010.00	$ 1,020.00
Assertive Field-Based Initiation for SUD Treatment Services	$ 110,050.00	$ 110,050.00	$ 110,050.00	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 5,000.00	$ 5,000.00	$ 5,000.00
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ 443,637.00	$ 449,174.00	$ 454,766.00	$ 350,000.00	$ 353,500.00	$ 357,035.00	$ 47,587.00	$ 48,063.00	$ 48,544.00
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 21,150,350.00	$ 21,616,879.00	$ 22,219,004.00	$ 19,327,576.00	$ 19,267,351.00	$ 19,459,014.00	$ 1,316,477.00	$ 1,329,592.00	$ 1,342,839.00
FSP Transfer Information	**Year One**	**Year Two**	**Year Three**						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**						
FSP Component Admin Expenses	$ 2,299,161.00	$ 2,067,127.00	$ 1,701,842.00						
Total Full Service Partnership Expenditures (auto-populated)	$ 23,449,511.00	$ 23,684,006.00	$ 23,920,846.00						
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**						
Eligible Children/TAY (25 years and younger)	350	355	360						
Eligible Adults/Older Adults	450	460	470						
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**						
MHSA "Encumbered" INN	$ -	$ -	$ -						

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

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 70: the overall total of Housing Intervention expenditures will be auto-populated from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.

Row 75: the proportion of funds dedicated to capital development will be auto-populated**.**

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated**.**

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

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

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

Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 15,409,678.00	$ 15,563,775.00	$ 15,719,413.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ 10,691,729.00	$ 10,691,729.00
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 15,409,678.00	$ 26,255,504.00	$ 26,411,142.00

Housing Interventions Category

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 7,159,258.00	$ 8,405,520.00	$ 8,626,758.00	$ 1,313,519.00	$ 3,227,034.00	$ 16,322.00
Operating Subsidies	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 5,820,000.00	$ 10,336,391.00	$ 11,655,552.00	$ 21,680,125.00	$ 7,110,808.00	$ 4,538,440.00
Operating Subsidies	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	9%	9%	9%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 300,000.00	$ 300,000.00	$ 300,000.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ -	$ 4,308,686.00	$ 2,396,485.00	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ 416,973.00	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 13,996,231.00	$ 23,650,597.00	$ 23,278,795.00	$ 22,993,644.00	$ 10,337,842.00	$ 4,554,762.00

Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -

Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ 1,413,447.00	$ 2,604,907.00	$ 3,132,347.00

Total Housing Interventions Expenditures (auto-populated)	$ 15,409,678.00	$ 26,255,504.00	$ 26,411,142.00
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 8,148,156.00	$ 18,632,090.00	$ 16,590,337.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 1,500,000.00	$ 1,500,000.00	$ 1,500,000.00
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	16.4%	9.1%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	52.9%	71.0%	62.8%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	5	5	5
Eligible Adults/Older Adults	296	296	296
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.

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

Instructions

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

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

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

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

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

Table Two: Other County Expenditures

Other Expenditures	Total Projected Expenditures (Year One)	Total Projected Expenditures (Year Two)	Total Projected Expenditures (Year Three)
Capital Infrastructure Activities	$ 5,000,000.00	$ 16,000,000.00	$ 5,000,000.00
Workforce Investment Activities	$ 1,028,074.00	$ 1,038,355.00	$ 1,048,739.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 45,205,999.00	$ 45,658,059.00	$ 46,114,640.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 41,179,560.00	$ 41,591,356.00	$ 42,007,270.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 92,413,633.00	$ 104,287,770.00	$ 94,170,649.00

Instructions

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

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

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

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

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

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

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

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

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 6,939,866.00
Local Prudent Reserve Maximum (1)	$ 11,070,813.04
Excess Prudent Reserve Funds (auto-populated)	$ (4,130,947.04)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -

Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ 2,164,989.00

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

Instructions

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

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

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

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

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

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

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

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

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

Table Three: Projected Annual Expenditures by County BH Funding Source

	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
BHSA	$ 101,215,302.00	$ 118,493,787.00	$ 119,678,725.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 44,266,981.00	$ 44,709,651.00	$ 45,156,748.00
2011 Realignment (Public Safety Realignment)	$ 23,334,691.00	$ 23,568,038.00	$ 23,803,718.00
State General Fund	$ 6,789,462.00	$ 6,857,357.00	$ 6,925,931.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 128,814,315.00	$ 130,102,458.00	$ 131,403,483.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 2,092,271.00	$ 2,092,271.00	$ 2,092,271.00
Substance Use Block Grant (SUBG)	$ 3,209,992.00	$ 3,209,992.00	$ 3,209,992.00
Commercial Insurance	$ 7,112,822.00	$ 7,183,950.00	$ 7,255,790.00
County General Fund	$ 4,186,175.00	$ 4,186,175.00	$ 4,186,175.00
Opioid Settlement Funds	$ -	$ -	$ -
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 16,792,250.00	$ 693,841.00	$ 700,779.00
Other state funding (including DSH funding)	$ 19,864,733.00	$ 20,063,380.00	$ 20,264,014.00
Other county mental health or SUD funding	$ 23,113,949.00	$ 38,666,367.00	$ 23,603,852.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**

Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 380,792,943.00	$ 399,827,267.00	$ 388,281,478.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 288,379,310.00	$ 295,539,497.00	$ 294,110,829.00
Auto-validation: Table 2: Other County Expenditures	$ 92,413,633.00	$ 104,287,770.00	$ 94,170,649.00

Budget Template Updates			
Version	**Revision Date**	**Description of Changes**	**Effective Date of Change**
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026

3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA "Encumbered" INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for "Improvement and Monitoring" (2% or 4%) and "Planning" (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to "No Excess" or "Reduce Excess"	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026

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
03242026_Behavioral Health Director Certification.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
Certification of BHSA funds.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
BOS Certification Template.FVsignature.7.14.26.pdf
Attachment-45760.pdf
Confirm that the data is up to date and reflects the correct information for a Final Plan

Requests

Funding Transfer Request

Please enter the proposed allocation adjustments to the tables below

	Plan year one	**Plan year two**	**Plan year three**
Behavioral Health Services and Supports (Base 35%)	42	42	42
Full Service Partnership (Base 35%)	35	35	35
Housing Intervention (Base 30%)	23	23	23

	Plan year one	Plan year two	Plan year three
Housing Interventions for Outreach and Engagement	0	0	0

Behavioral Health Services and Supports Transfers

Enter the proposed dollars transferred into/from Behavioral Health Services and Supports (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred from Housing Intervention	4690000	4690000	4690000
Dollars transferred into Full Service Partnerships	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred into Housing Intervention	0	0	0

For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request

The County is requesting to transfer 7% of the unallocated Housing component allocation to the BHSS component to minimize reductions in programs in the BHSS Component.

Full Service Partnership Transfers

Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Housing Intervention	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred into Behavioral Health Services and Supports	0	0	0
Dollars transferred into Housing Intervention	0	0	0

For Full Service Partnership, please include a rationale for the funding allocation transfer request

N/A

Housing Interventions Transfers

Enter the proposed dollars transferred into/from Housing Interventions (Base 30 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred into Behavioral Health Services and Support	4690000	4690000	4690000
Dollars transferred into Full Service Partnerships	0	0	0

For Housing Intervention, please include a rationale for the funding allocation transfer request

The Housing component will have unspent allocation for this 3-year Plan. The County is requesting to transfer 7% of the housing component to the BHSS component to minimize reductions in the BHSS bucket.

Supporting Information and Data

How does the funding transfer request respond to community needs and input?

From the inception of Prop. 1 the community has raised concerns regarding the reduction and/or elimination of a number of our core MHSA programs, specifically related to consumer wellness and treatment services essential to the unserved and underserved communities and populations most effected by mental health challenges. With this transfer request, the county is able to maintain essential treatment programs that our community has requested, i.e. Wellness Center programming, non-FSP services for TAY, Justice Programming, and critical Crisis Expansion services. The county conducted three community planning stakeholder meetings, March 18, 2026 at the BHSA Consortium, and the Behavioral Health Advisory Board and at the BHS Leadership Meeting on March 19, 2026. Stakeholders from the meetings

agreed with the decision and applauded the efforts to utilize unallocated housing component funds to cover the costs for these essential core services.

Please include local data supporting the funding transfer request

2026 Housing Component Presentation.TransferRequestPresentation.pdf

Data Suppression Notice:

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

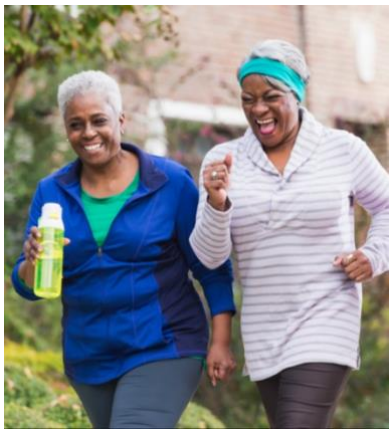
SAN JOAQUIN COUNTY

Greatness grows here.

APPENDIX

2025 SJC COMMUNITY HEALTH NEEDS ASSESSMENT (FINAL)
2026 QAPI WORK PLAN (FINAL)
2024-2025 PEI ANNUAL REPORT
BH DIRECTOR CERTIFICATION
CAO CERTIFICATION
BOS CERTIFICATION

SAN JOAQUIN COUNTY | 2026



San Joaquin County 2025 Community Health Needs Assessment

April 2025

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Executive Summary

Introduction

San Joaquin County is one of California's fastest growing counties; it encompasses 1,426 square miles, with 35 square miles of water and waterways, and includes eight cities, many small towns, and several rural farm and ranching communities that are home to diverse racial and ethnic populations. San Joaquin is a county of contrasts, home to enormous economic wealth and community growth opportunities and a variety of assets and resources to support health, while facing significant challenges in terms of economic and health disparities.

CHNA Background

The San Joaquin County 2025 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health that encompasses the conditions that impact health in the County. The overall goal of the CHNA is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents. From data collection and analysis to the identification of prioritized needs, the development of the CHNA report has been an inclusive and comprehensive process guided by a Core Team planning group and broadly representative Steering Committee, with input from hundreds of community residents. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

Conducting a CHNA every three years fulfills a long-standing California requirement for nonprofit hospitals as well as a federal mandate to maintain tax-exempt status; in addition, it is a requirement for Public Health Accreditation and satisfies mandates for Managed Care Plans. San Joaquin County's CHNA is unique in that all its non-profit hospitals, the county Managed Care Plans, the local health department and key stakeholders join together to support one countywide assessment. The process in 2025 included interviews with 12 key informants, 40 focus group discussions with 350 community residents, and data analyses of over 100 indicators, creating a robust picture of the issues affecting people's health where they live, work, and play.

The CHNA process applied a social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health, in addition to exploring factors related to diseases, clinical care, and physical and mental health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the County. This CHNA report places particular emphasis on the health issues and contributing factors that impact populations that have poor health outcomes across multiple health needs. It identified specific geographic areas referred to as "Priority Neighborhoods" and explores health disparities

for populations residing in them, as well as disparities among the entire County's diverse population. These analyses will inform intervention strategies to promote health equity.

Highest priority health needs

Through a comprehensive process combining findings from demographic and health data, as well as community leader and resident input, ten health needs were identified (see box). A multi-step prioritization method identified the following three health needs as the highest priorities for San Joaquin County. See Section 7 for the full Health Need Profiles and Appendix A and B for secondary data descriptions, sources, and dates.

CHNA Health Needs

Highest Priority
- Access to Care
- Mental/Behavioral Health including Substance Use
- Chronic Disease/HEAL

Medium Priority
- Housing
- Economics
- Social Support

Lower Priority
- Community Safety
- Education
- Food Security
- Transportation

Access to Care: Access to comprehensive, quality healthcare is important for health and for increasing and maintaining a high quality of life. In San Joaquin County, residents have access to significantly fewer health care providers (including mental health providers) than the California average, which contributes to long wait time for appointments, limited clinic hours, the need to travel for specialty care, and frustration with and distrust of the medical system. Lack of prenatal care and lower rates of health insurance, especially among women of color, can be linked to the higher percentage of poor outcomes for infants. Key informants and focus group participants emphasized the need for culturally and linguistically competent providers, as well as assistance with insurance applications and other healthcare paperwork. Key informants and focus group participants noted the success of pop-up and mobile COVID-19 vaccination and testing clinics established in partnership with community-based organizations, which created access points for other health care services in underserved areas; they suggested that this model be maintained and expanded to address a variety of health needs.

Mental Health Including Substance Use: Mental health affects all areas of life, including a person's physical well-being and ability to work, to perform well in school, and to participate fully in family and community activities. Residents of San Joaquin County have a higher rate of deaths by suicide, drug overdose, and alcohol poisoning combined than the California average, with significantly fewer mental health care providers available. Participants in almost two-thirds of the focus groups described mental health as the number one health issue within their communities, and, along with key

informants, expressed particular concern for children's mental health and the associated increase in drug, alcohol, and vaping use among children and teens. Key informants and focus group participants pointed out the intersection of mental health needs, substance use, and homelessness, and stressed the urgent necessity for diverse providers, timely crisis intervention services, improved access to mental health care in rural areas, and services tailored to the needs of underserved groups.

Chronic Disease/Healthy Eating, Active Living (HEAL): Chronic diseases are a primary cause of poor health outcomes and death and a leading driver of health care costs. The rates of diabetes and obesity among adults in San Joaquin County are higher than California overall, as are the rates of heart disease and stroke deaths – all conditions that have persisted for many years. Black/African American County residents have the highest rates of diabetes, pediatric asthma prevalence, and hospitalizations for cardiovascular disease, and the highest incidence of colorectal and lung cancer among all ethnicities/races. Focus group participants and key informants ascribed high chronic disease rates to the pervasive presence of unhealthy processed/fast foods, lack of affordable healthy foods, food deserts, community barriers to physical activity, and limited access to healthcare. These are especially present in communities/neighborhoods with a high percentage of low-income residents, people of color, and immigrants.

Next steps

San Joaquin County will use the results of this CHNA to drive the development of a Community Health Improvement Plan (CHIP). The CHIP will identify strategies and actions to address health needs using a collaborative approach. It will leverage resources and skills from a variety of County organizations and agencies to maximize the potential for collective impact that results in sustainable changes for County residents.

The hospitals involved in the CHNA will each develop a complementary Implementation Strategy (IS) plan to outline how they will address priority health needs. These strategies will build on a hospital's own assets and resources, as well as on evidence-based strategies and best practices, wherever possible. Their IS reports will be filed with the Internal Revenue Service. Both the San Joaquin County CHNA and the IS reports, once finalized, will be posted publicly on each of the hospitals' websites.

The 2025 CHNA report and the subsequent CHIP will be available at www.healthiersanjoaquin.org

I. Introduction/Background

The San Joaquin County 2025 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health that encompasses the conditions and challenges that impact health in the County. The overall goal is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents.

The San Joaquin County community has a long tradition of working collaboratively and has conducted a joint triennial CHNA for many years. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

San Joaquin County will use the results of this CHNA to drive the development of a joint Community Health Improvement Plan (CHIP), which will identify long-term, systematic strategies and actions to address health needs. Community partners across the County will work together to set priorities and coordinate and target resources. The 2025 CHNA report will be available at www.healthiersanjoaquin.org.

The hospitals involved in the CHNA will each develop an Implementation Strategy (IS) plan to outline how they will be addressing priority health needs. These strategies will build on a hospital's own assets and resources, as well as on evidence-based strategies and best practices, wherever possible. Their IS reports will be filed with the Internal Revenue Service.[1] Both the CHNA and the IS reports, once finalized, will be posted publicly on each of the hospitals' websites.

A. Purpose of the Community Health Needs Assessment (CHNA) Report

Conducting a triennial CHNA has been a California requirement for nonprofit hospitals for more than 30 years (SB 697).[2] The Patient Protection and Affordable Care Act (ACA) adopted a federal model similar to regulations already in place in California, making the CHNA a national mandate for nonprofit hospitals to maintain their tax-exempt status. Section 501(r) of the Internal Revenue Code now requires all nonprofit hospitals to conduct a CHNA and develop an IS every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

Additionally, this 2025 San Joaquin County CHNA fulfills San Joaquin County Public Health Services' requirement to maintain its national Public Health Accreditation.[3] This report also fulfills the mandate for Managed Care Plans (MCPs) to meet standards for

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[1] Charitable hospitals - general requirements for tax-exemption under Section 501(c)(3) | Internal Revenue Service

[2] Hospital Community Benefits Plan - HCAI

[3] Standards & Measures for Reaccreditation Version 2022

Population Health Management programs and National Committee for Quality Assurance (NCQA) Health Plan Accreditation.[4,5] By 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation, with the goal of ensuring equitable, coordinated, and person-centered services, and improving health outcomes.

From data collection and analysis to the identification of prioritized needs, the development of the CHNA report has been an inclusive and comprehensive process guided by a Core Team planning group and a broadly representative Steering Committee. Opinions were sought from decision makers and key stakeholders and more importantly, from a diverse cross-section of residents whose voices are not often heard. As many community members as possible were engaged in the CHNA process.

B. Description of the CHNA Process

The CHNA was a collaborative examination of health in San Joaquin County, updating and building on work done in prior years, including many of the themes identified in previous CHNA cycles. The CHNA process applied a social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the County.

The CHNA assessed the health issues and contributing factors with greatest impact among populations that have poor health outcomes across multiple health needs. The CHNA explored disparities for populations residing in specific geographic areas referred to as "Priority Neighborhoods", as well as disparities among the County's diverse ethnic populations. These analyses will inform intervention strategies to promote health equity.

The CHNA utilized a mixed-methods approach. San Joaquin County Public Health Services epidemiologists compiled a comprehensive set of secondary data from national, statewide, and local sources to provide a multi-faceted picture of health in San Joaquin County. These data were compared to benchmark data and analyzed to identify potential areas of need. In addition, Ad Lucem Consulting, in concert with the Core Team, collected primary data via key informant interviews and focus groups that offered a wide range of opinions about issues that most impact the health of the community, as well as examples of existing resources that work to address those needs, and suggestions for continued progress in improving these issues. The analyzed

[4] CALAIM: Population Health Management (Phm) Policy Guide
[5] Population Health Management

quantitative and qualitative data were triangulated to identify the top health needs in the County. A summary health need profile was then created for each of these.

Health needs were ranked as highest, medium, and lower priority based on the points received after scoring each health need on quantitative and qualitative dimensions. These methods, the data collected, and the resulting prioritized community health needs are presented in this report and in the appendices.

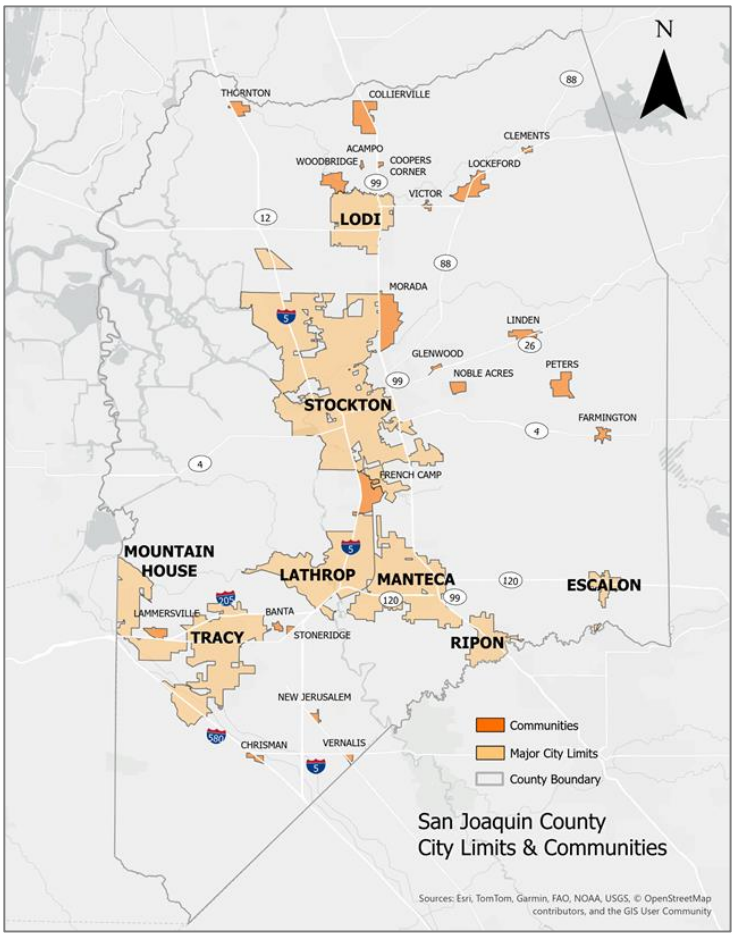
II. Community Served

A. Definition of Community Served

Each hospital participating in the San Joaquin County CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. For this joint CHNA, the hospital partners chose San Joaquin County as the primary service area.

B. Map and Description of Community Served

Figure 1. Map of San Joaquin County



i. Geographic Description of the Community Served

San Joaquin County, in the Central Valley of California, is roughly 60 miles east of San Francisco and 35 miles south of Sacramento, with a total population of 779,445 (2022). Historically, agriculture has been a strong driver of the economy, and many migrants and immigrants have settled in the County to work as farm laborers, in agricultural processing, or in shipping. The County encompasses an area of 1,426 square miles, with 35 square miles of water and waterways, and includes 8 cities (Escalon, Lathrop, Lodi, Manteca, Mountain House, Ripon, Stockton, and Tracy) as well as many ranching and farming communities scattered across the County (Figure 1).

ii. Climate and Environment of the Community Served

San Joaquin County's climate is shaped by its location on the northern end of the San Joaquin Valley, an area bounded by mountains to the north and east and the Sacramento-San Joaquin River Delta to the west. The region's weather is characterized by hot, dry summers and mild, wet winters. Risks to health from a changing climate are a growing concern in San Joaquin County, as environmental extremes – such as drought, heat, flooding and pollution-related catastrophes – increase in frequency and intensity (Table 1). The County performs substantially worse than California overall on a number of climate measures.

Table 1. Climate and environmental measures – San Joaquin County

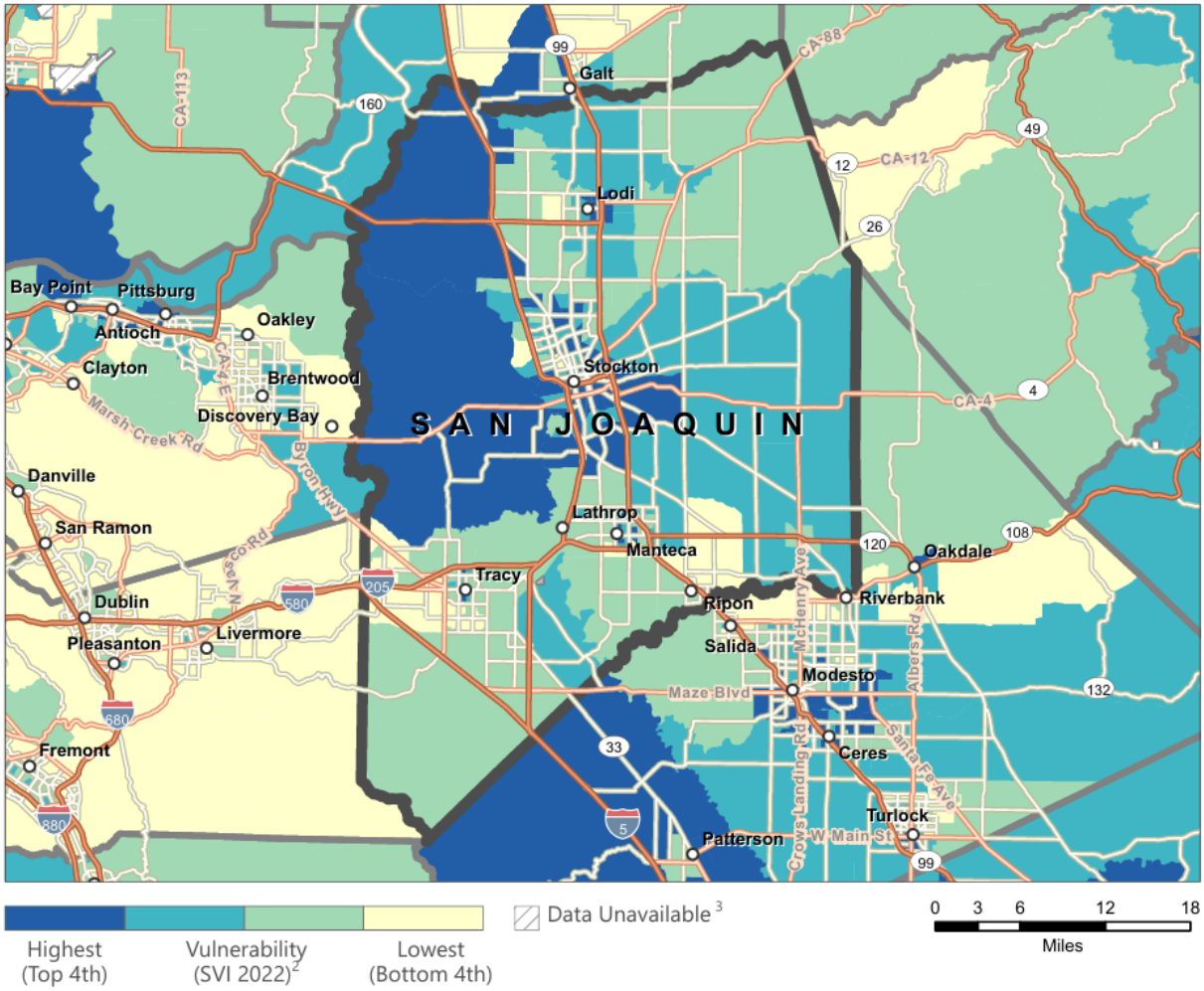
	SJC Measure	CA Measure	SJC Significantly Worse than CA
Drought risk *	100	3	Yes
Heat wave risk *	96	8	Yes
Air pollution: PM2.5 concentration ‡	11	10	No
Water Contaminants ‡	661	478	Yes
River flooding risk ∞	58	29	Yes

Sources: *FEMA National Risk Index, ‡CalEnviroscreen 4.0, ∞Kaiser Permanente Community Health Data Platform, 2025

Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The CDC/ATSDR Social Vulnerability Index County Map (Figure 2) depicts the social vulnerability of communities, at census tract level, within San Joaquin County. The SVI groups sixteen factors into four themes that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and

vehicle access. Overall social vulnerability combines all the variables to provide a comprehensive assessment. The map below indicates that large areas of western and eastern San Joaquin County fall into the two highest vulnerability categories.

Figure 2. Social Vulnerability Index Map – San Joaquin County



Source: Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry SVI Interactive Map, California2022_San Joaquin County.pdf, 2022

iii. Demographic Profile of the Community Served

San Joaquin County is one of California's fastest growing counties, home to diverse racial and ethnic populations. San Joaquin is a county of contrasts; there is enormous economic wealth and community growth opportunities and a variety of assets and resources to support health, however, San Joaquin County faces significant challenges in terms of economic and health disparities. A plurality of residents is Hispanic/Latino, and almost a quarter of residents are foreign-born. While many within the County are economically secure, nearly 13% of residents live in poverty. Children have a poverty

rate of over 17%, and more than 1 in 10 residents aged 65 years and older live in poverty. The educational attainment of San Joaquin County residents is much lower than California residents; about 20% of County adults have no high school diploma, compared to 16% of adult Californians, and a much bigger gaps exists between the percent of County residents with a college degree (20%) versus California overall (36%). See Table 2 for a summary of County population demographics.

Table 2. Demographic Profile – San Joaquin County

Race/ethnicity*	
Total Population	**779,445**
Hispanic/Latino	**43%**
Non-Hispanic/Latino	**57%**
White	*29%*
Asian	*17%*
Black/African American	*7%*
Multiple races	*4%*
Pacific Islander/Native Hawaiian	*1%*
American Indian/Alaska Native	*0.2%*

Source: US Census, 2022
*Percentages may not equal 100% due to rounding

Median household income	$82,837
Living in poverty (<100% Federal poverty level)	13%
Children in poverty	17%
Older adults (ages 65+) in poverty	11%
Employed (ages 16+)	57%
Medicaid/public insurance enrollment	43%
Insured (ages 19-64 years)	91%
Adults with no high school diploma	20%
Bachelor's Education or higher	20%

Source: US Census, 2022

Many languages are spoken in San Joaquin County (Table 3), with almost half of the population speaking a language other than English at home. The top five non-English languages spoken at home are Spanish, Tagalog (incl. Filipino), Punjabi, Khmer, and Vietnamese. Of the Asian and Pacific Island languages, more than half of Chinese (64%), Korean (57%), Vietnamese (54%), and other languages of Asia (72%) speakers communicate in English less than "Very Well".

Table 3. Languages Spoken at Home[6] and Ability to Speak English (Population 5 Years and Older) – San Joaquin County

	Number of Speakers	Percent of Speakers	Speak English less than "Very Well"	Percent Who Speak English less than "Very Well"
Population 5 years and over	735,401	n/a	133,872	18%
Speak only English at home	412,408	56%	n/a	n/a
Speak a language other than English at home	337,724	46%	133,872	40%
Non-English languages spoken at home*				
Spanish	209,017	28%	83,806	40%
Punjabi	20,251	35%	8,391	41%
Chinese (incl. Mandarin, Cantonese)	6,353	10%	4,034	64%
Hmong	5,813	9%	2,450	42%
Vietnamese	7,999	12%	4,328	54%
Khmer	8,794	13%	4,378	50%
Tagalog (incl. Filipino)	27,539	41%	11,206	41%
Ilocano, Samoan, Hawaiian, or other Austronesian languages	5,597	8%	2,382	43%

Source: U.S. Census Bureau, 2023 American Community Survey 1–Year Estimates, Table B16001.
* This table includes only languages spoken by 5000 or more county residents; for more information contact Public Health Services.

iv. Hospitals and Health Professional Shortages in the Community Served

Residents of San Joaquin County have access to hospitals and medical centers, including:

- Adventist Health Lodi Memorial
- Dameron Hospital
- Doctors Hospital of Manteca
- Kaiser Permanente Manteca Medical Center
- San Joaquin General Hospital
- St. Joseph's Medical Center
- Sutter Tracy Community Hospital

[6]Only languages with 5000 or more speakers included in the table. For additional information on languages spoken at home in SJC, please contact San Joaquin County Public Health Services.

Several of the above facilities have representation on the CHNA Core Team.

San Joaquin County has 16 Health Professional Shortage Areas (HPSA) and one Medically Underserved Area/population (MUA/P) (Table 4), covering specific populations and health care facilities.[7] The San Joaquin County populations included in the HPSA designations include low income, homeless, migrant, and farmworker populations, and the facilities include Federally Qualified Health Centers; Federally Qualified Health Centers Look-Alikes; and Indian Health Service, Tribal Health, and Urban Indian Health Organizations. The majority of the County's HPSAs and the MUA/P are in non-rural areas.

Table 4. HPSAs and MUA/Ps – San Joaquin County

Number of HPSAs	
Primary Care	6
Dental Health	5
Mental Health	5
Number of MUA/Ps	
Primary Care	1

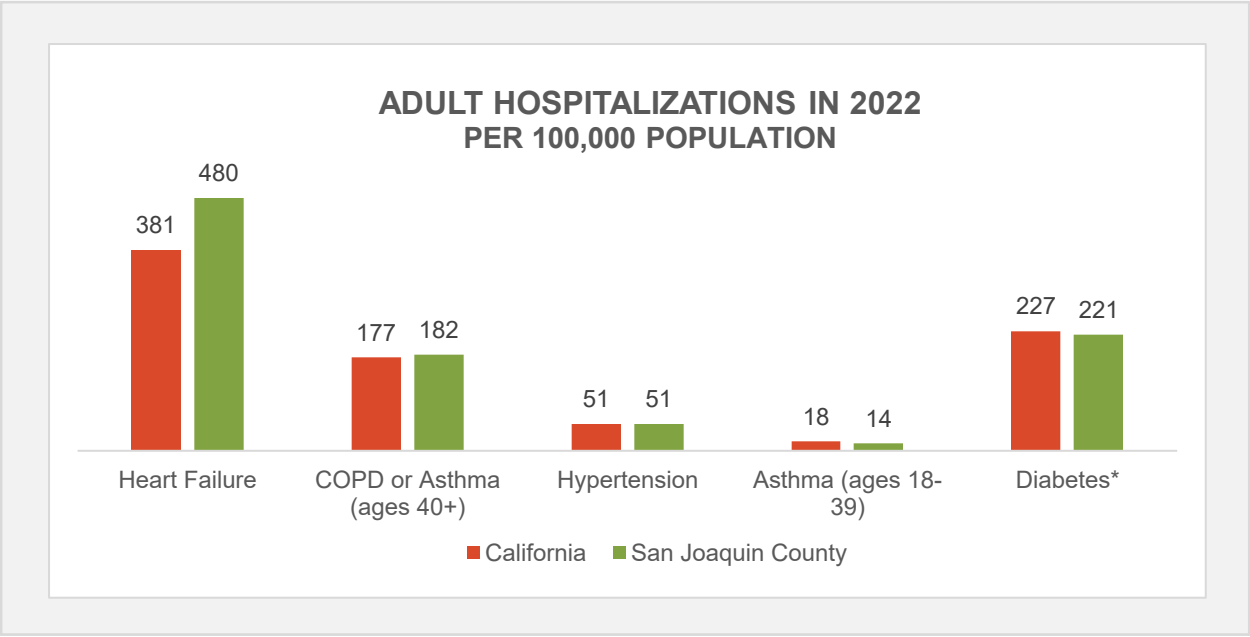
Source: HPSA Find, 2021-2024

v. Hospitalizations and Leading Causes of Deaths of the Community Served

The California Health and Human Services Agency tracks the rates of hospitalizations for common chronic conditions for each county. San Joaquin County had higher (risk-adjusted) rates of adult hospitalization for heart failure and COPD/asthma (ages 40+) than California overall, and a comparable rate of hospitalization for hypertension in 2022 (Figure 3). Many of these hospitalizations could potentially be avoidable through access to high-quality outpatient care.

[7] A Health Professional Shortage Area (HPSA) is a federal designation created by the National Health Service Corps for a geographic area, population, or facility with a shortage of primary, dental, or mental health care providers. Medically Underserved Areas/Populations (MUA/P) identify geographic areas and populations with a lack of access to primary care services. These designations help distribute personnel and resources where they're needed most, and establish health maintenance organizations or community health centers, respectively.

Figure 3. Adult Hospitalizations – San Joaquin County and California



Source: CA Health and Human Services Open Data Portal

*Composite of short term, long term, and uncontrolled diabetes hospitalizations, as well as diabetes-related amputations

From 2019 to 2023, the top five causes of death in San Joaquin County were heart disease, cancer, COVID-19, unintentional injuries, and stroke (Table 5). The top five causes of death differed by race/ethnicity. Heart disease and cancer were among the top five causes of death for all racial/ethnic groups, but unlike other racial/ethnic groups in the County, cancer was the leading cause of death among Asian and Hispanic/Latino residents. Unintentional injuries were in the top five causes of death for Black/African American, White, multiracial, and residents of unknown race/ethnicity. COVID-19 was a leading cause of death for all races/ethnicities except for White residents. Deaths of despair (deaths due to suicide, alcohol related disease, and drug overdoses) primarily affected White, multiracial, and residents of unknown race/ethnicity, while diabetes mortality was among the top five causes of death only for Asian and Native Hawaiian/Pacific Islander residents.

Table 5. Top Five Causes of Death – San Joaquin County*

	San Joaquin County	Asian	Black/ African/ American	Hispanic	American Indian/ Alaska Native	Native Hawaiian/ Pacific Islander	White	Multiple Races	Other Unknown
1	Heart Disease	Cancer	Heart Disease	Cancer	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Heart Disease	Cancer	Heart Disease	Cancer	Stroke	Cancer	Cancer	Cancer
3	COVID-19	Stroke	Unintentional Injuries	COVID-19	Stroke	Cancer	Unintentional Injuries	Unintentional Injuries	Deaths of Despair
4	Unintentional Injuries	COVID-19	COVID-19	Unintentional Injuries	COVID-19	COVID-19	Deaths of Despair	Deaths of Despair	Unintentional Injuries
5	Stroke	Diabetes	Stroke	Stroke	Lung Disease	Diabetes	Lung Disease	COVID-19	COVID-19

Source: San Joaquin County Public Health Services
*The death data is a 5-year average, age-adjusted rate, 2019-2023

III. Who Was Involved in the Assessment?

A. Identity of Partner Organizations that Collaborated on the Assessment

The San Joaquin County CHNA was an effort of the Healthier San Joaquin Collaborative that included San Joaquin Public Health Services, San Joaquin's Managed Care Plans and nonprofit hospitals as well as many partner organizations and individuals throughout the community. The CHNA was led by a Core Team that was responsible for planning and key decision-making, including providing input on data collection instruments, working alongside Ad Lucem Consulting to collect and analyze data, and reviewing and commenting on this report. The broadly representative CHNA Steering Committee supported the process by collecting primary data and participating in data review and interpretation.

i. Core Team Members

- Adventist Health Lodi Memorial
- Behavioral Health Services
- Community Foundation of San Joaquin
- Community Medical Centers
- Dameron Hospital
- Dignity Health St. Joseph's Medical Center
- First 5 San Joaquin
- Health Net
- Health Plan of San Joaquin
- Kaiser Permanente
- Reinvent South Stockton Coalition
- San Joaquin County Public Health Services
- SJ Health
- Sutter Health
- University of the Pacific

ii. Steering Committee Members

- 211 San Joaquin
- Adventist Health Lodi Memorial*
- Amelia Adams Whole Life Center
- Asian Pacific Self-Development and Residential Association (APSARA)
- Behavioral Health Services*
- Boys and Girls Club
- Catholic Charities Diocese of Stockton
- Child Abuse Prevention Council
- City of Stockton
  - Office of the Mayor
  - Office of Violence Prevention
- Community Foundation of San Joaquin*
- Community Medical Centers*
- Dameron Hospital*
- LOVE Inc. Manteca
- Mary Magdalene Community Services Public Health Advocates
- Reinvent South Stockton Coalition*
- San Joaquin Community Foundation
- San Joaquin PRIDE Center
- Sierra Vista Homes, Residents Council
- SJC Behavioral Health Services
- SJC Children's Alliance
- SJC Council of Governments
- SJC Office of Education
  - Early Childhood Education
  - Comprehensive Health Programs
- SJC Health Care Services Agency

- Data Co-op
- Delta Health Care
- Department of Health and Human Services, Region 9
- Dignity Health, St. Joseph's Medical Center and Behavioral Health Center*
- El Concilio
- Emergency Food Bank
- Faith in the Valley
- First 5 San Joaquin*
- Health Force Partners
- Health Net*
- Health Plan of San Joaquin*
- Hispanic Chamber of Commerce
- Kaiser Permanente*
- Little Manila Rising
- SJC Human Services Agency: Aging and Community Services
- SJC Public Health Services*
- SJ Health*
- St. Mary's Dining Room
- Stocktonians Taking Action to Neutralize Drugs (STAND)
- Stockton NAACP
- Sutter Health*
- Third City Coalition
- University of the Pacific, School of Health Sciences*
- Visionary Home Builders
- Women's Center and Youth Services Agency

**Core Team Member*

iii. San Joaquin County Community Residents

The San Joaquin County CHNA would not have been possible without the support and engagement of County residents. Three hundred and fifty community residents volunteered their time as focus group participants to provide the critical perspectives of residents living, working, and raising families in County communities.

Other County residents supported the CHNA process by providing feedback/validation of the preliminary findings during meetings with community groups; participants in these meetings agreed with the health challenges and opportunities that emerged from the CHNA analysis.

B. Identity and Qualifications of Consultants Used to Conduct the Assessment

The Healthier San Joaquin Collaborative contracted with Ad Lucem Consulting, a public health consulting firm, to conduct the San Joaquin County CHNA.

Ad Lucem Consulting has developed CHNA reports and Implementation Strategy Plans for hospitals and health departments including synthesis of secondary and primary data, needs prioritization, and identification of assets and implementation strategies.

To learn more about Ad Lucem Consulting, visit www.adlucemconsulting.com.

IV. Process and Methods Used to Conduct the CHNA

A. Secondary Data

i. Sources and Dates of Secondary Data Used in the Assessment

The data used for this CHNA was compiled by San Joaquin County Public Health Services (PHS) and generally follows the health needs organization and indicators found in the Kaiser Permanente (KP) Community Health Data Platform (KP Platform)[8]. The most up-to-date data were included (e.g. American Community Survey 2022, Vital Records Business Intelligence System 2019-2023, etc.), and data by race/ethnicity were also compiled, as well as a number of additional demographic indicators.

For details on specific definitions, sources and dates of the data used, please see Appendix A. Data for health status, behavior, and risk factor indicators can be found in Appendix B.

ii. Methodology for Collection, Interpretation, and Analysis of Secondary Data

The data included in this CHNA presents a focused set of community health indicators that allows readers to understand what is driving health outcomes in San Joaquin County, including understanding racial/ethnic disparities and comparing local indicators with state benchmarks.

The KP Platform "Health Topics" were used as a general framework for the CHNA measures. The KP Platform did not have measures by race/ethnicity, therefore, PHS staff attempted to gather the information from the defined data sources.

The main goals for secondary data collection and analysis were the following:

- To compare San Joaquin County values to state values and measure divergence (% above or below).
- To gather San Joaquin County indicator data by racial/ethnic group and measure divergence from the San Joaquin County benchmark and the White population.
- To compare Priority Neighborhood values to San Joaquin County values and measure divergence (% above or below).
- To track change over time between the 2022 CHNA and 2025 CHNA.
- To show rate stability by calculating statistical significance for each measure, if available.

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[8] Kaiser Permanente. (2025). *Community Health Data Platform.* Oakland, CA. 2025 Community Health Needs Dashboard | Tableau Public

Analysis of the secondary data included assigning a score to each health need (4: very high, 3: high, 2: medium, 1: lower) based on the number of indicators within the health need that were statistically significantly worse than state benchmarks. The majority of health needs had at least one indicator for which racial/ethnic disparity data were available; an additional score was assigned to each health need based on the number of racial/ethnic groups for whom each indicator was significantly worse than for White residents.

B. Community Input

i. Description of Who Was Consulted

Community input was provided by a broad range of community members using key informant interviews, focus groups and community meetings. The Steering Committee engaged community-based organizations to reach individuals with the knowledge, information, and expertise relevant to the health needs of the community. These individuals included representatives from local governmental and public health agencies; community-based organizations; and leaders, representatives, and members of underserved, low income, unhoused, and racial/ethnic populations. Additionally, where applicable, other individuals with expertise on local health needs were consulted. For a complete list of individuals who provided input, see Appendix C.

ii. Methodology for Collection and Interpretation

Key Informant Interview Methodology

Ad Lucem Consulting conducted key informant interviews with 12 individuals representing diverse sectors including: public health, health care, community-based organizations, and social services. The key informants were identified by Healthier San Joaquin Collaborative Core Team members.

All interviews were conducted by telephone in English and took approximately 30-45 minutes to complete. The interviews followed a standard set of interview questions and the interviewer took detailed notes during the call. At the beginning of the interview, confidentiality was assured, and the respondents were invited to skip questions that were not applicable to the respondent's experience.

Interview topics: Interview questions were developed by Ad Lucem Consulting with input from Core Team members. For the complete list of interview questions, see Appendix D. Questions addressed the following topics:

1. Top health issues in San Joaquin County
2. Factors and challenges that contribute to the top health issues, including lasting impacts of the COVID-19 pandemic

3. Populations most impacted by the top health needs (e.g., low income, racial/ethnic subpopulations)
4. Successful strategies and community assets to address top health issues
5. Notable gaps in services or assets

Data Analysis: Ad Lucem Consulting used software to code and analyze responses by health need. The number of mentions for all themes related to a particular health need were tallied to develop an interview data score. Health needs were assigned points based on the frequency of mentions of the health need by key informants. Points for each health need were tallied across interviewees to develop interview scores for health need priority, racial/ethnic disparities, geographic or other disparities.

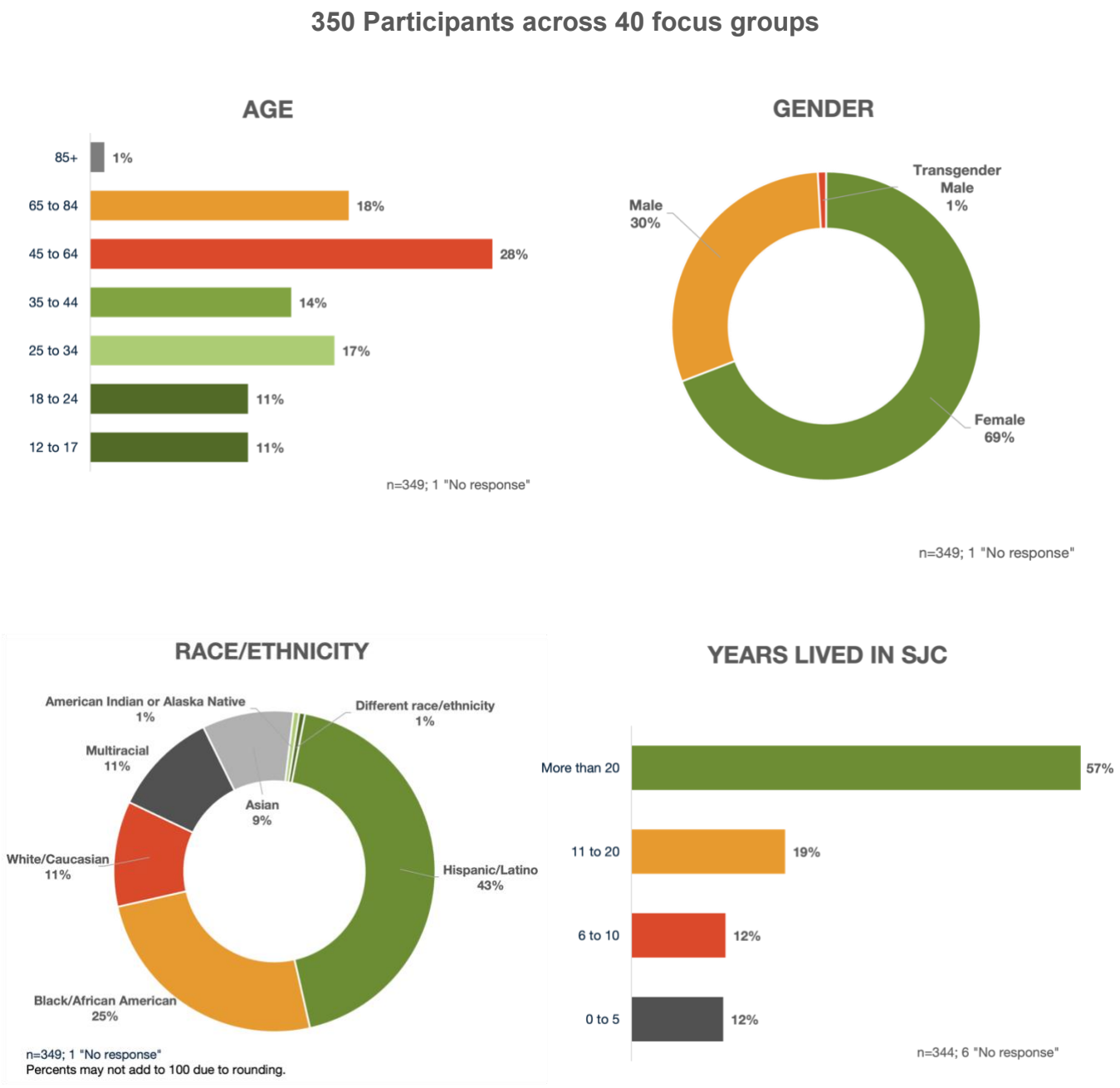
Focus Group Methodology

Forty community resident focus groups were conducted in geographic areas within San Joaquin County, including Stockton, Lodi, Tracy, Manteca, French Camp, and Thornton. Most groups were conducted in English; four groups were conducted in Spanish, two in Hmong and one in Cambodian. Participants included teens, adults, and older adults who represented underserved, low income and racial/ethnic communities. Figure 4 presents the demographic characteristics of the focus group participants.

Communities/populations participating in focus groups:

- Adults
- Black/African American community
- Cambodian community
- Foodbank users
- Hispanic/Latino community
- Justice system involved residents
- Migrant workers
- LGBTQIA+ community
- Opioid safety stakeholders
- Residents living with chronic diseases and disabilities
- Residents from specific SJC geographies
- Unhoused residents
- Youth

Figure 4. Focus Group Participant Profile – San Joaquin County



Representatives from community-based organizations (CBOs) and public agencies who were members of the CHNA Steering Committee were trained by Ad Lucem Consulting to conduct focus groups with community residents. This approach allowed for a large number of focus groups to capture the diverse perspectives of many County subpopulations. CBOs/public agencies attending the training received instruction on a 10-step focus group process, including participant recruitment, focus group logistics, focus group facilitation, note taking and summarizing the focus group discussion. The training participants received a toolkit which included a focus group manual describing the 10 steps as well as the focus group guide and instructions on returning the focus group materials. The CBOs/public agencies had the opportunity to apply for funds to support focus group logistics and focus group participants were each provided with a $50 gift card as thanks for their participation.

CBO/public agency staff recruited participants and organized logistics for the focus groups. Each focus group session averaged 60 minutes and was facilitated by a participating CBO/agency. Six out of the 40 focus groups used a virtual format. During the focus group, CBO/public agency staff members took notes (either the focus group facilitator or a co-moderator); CBOs/public agencies were instructed to use the notes to prepare a focus group summary on a template provided in the toolkit. CBOs/public agencies emailed focus group summaries and demographic questionnaires to Ad Lucem Consulting for data entry and analysis.

Focus group question guide: A focus group guide ensured consistency across groups. The focus group questions were developed by Ad Lucem Consulting with input from the Core Team. The questions were translated into Spanish by a native Spanish speaker experienced in translation. For focus groups conducted in Hmong and Cambodian, the focus group facilitator translated the focus group questions themselves. At the beginning of each focus group session, participants were welcomed and assured anonymity of their responses. An overview of the discussion was provided as well as a review of discussion ground rules. For the complete list of focus group questions, see Appendix E. Questions addressed the following topics:

1. What is healthy about the community
2. What makes it difficult to be healthy in the community
3. Top health issues in the community
4. Groups/populations most affected by the top health issues
5. Strategies to address the top health issues

Data Analysis: Summaries of focus group discussions were prepared by the CBOs/agencies who facilitated the focus groups and were submitted to Ad Lucem Consulting. The most prominent themes in the focus group summaries were identified,

and health topics discussed by focus group participants were organized into the health need categories defined by the secondary data. Ad Lucem Consulting used software to code and analyze responses by health need. Health needs were assigned points based on the frequency and importance given to the health need by focus group participants. Points for each health need were tallied across focus groups to develop scores for health need priority, racial/ethnic disparities and geographic or other disparities.

In addition to the community resident focus groups described above, a meeting of the Resilient Community Advisory Committee took place in November 2024, at which a focus group-like discussion was led by San Joaquin County Public Health Service staff. The 39 attendees represented a wide cross-section of community-based organizations and entities serving historically disenfranchised populations within the County. The discussion highlighted issues related to several health needs, including chronic disease/HEAL, community safety, and housing. The Resilient Community Advisory Committee perceived these issues as ripe for policy interventions that could be included in the CHIP.

iii. San Joaquin County Reports and Assessments

A number of San Joaquin County partners have published documents that contribute to the overall understanding of the local social, environmental, and economic conditions that impact residents' health. These documents were reviewed as part of the CHNA assessment to highlight health issues and contributing factors for the County's historically underserved populations. This information can inform intervention strategies to promote health equity. For the complete annotated bibliography, see Appendix F.

C. Written Comments

Each hospital has provided the public an opportunity to submit written comments on the facility's previous CHNA Report through their website. These websites will continue to allow for written community input on each facility's most recent CHNA Report.

As of the time of this CHNA report development, members of the Core Team had not received written comments about the previous CHNA report. Core Team members will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate facility staff.

D. Data Limitations and Information Gaps

The CHNA data platform includes over 100 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are limitations with regard to these data, as is true with any secondary data:

- Some data were only available at a county level and did not contribute to the understanding of Priority Neighborhood needs.
- A number of indicators reported rely on the Census/American Communities Survey which may be based on small sample sizes and are estimates rather than actual measures.
- Disaggregated data around ethnicity/race are not available for all data indicators, which limited the ability to examine some health disparities.
- Data are not always collected on a yearly basis, and some data are several years old.

Primary data collection is also subject to limitations:

- Themes identified during interviews and focus groups were likely dependent upon the experiences of individuals selected to provide input; input from a robust and diverse group of stakeholders sought to minimize this bias.

V. Priority Neighborhoods

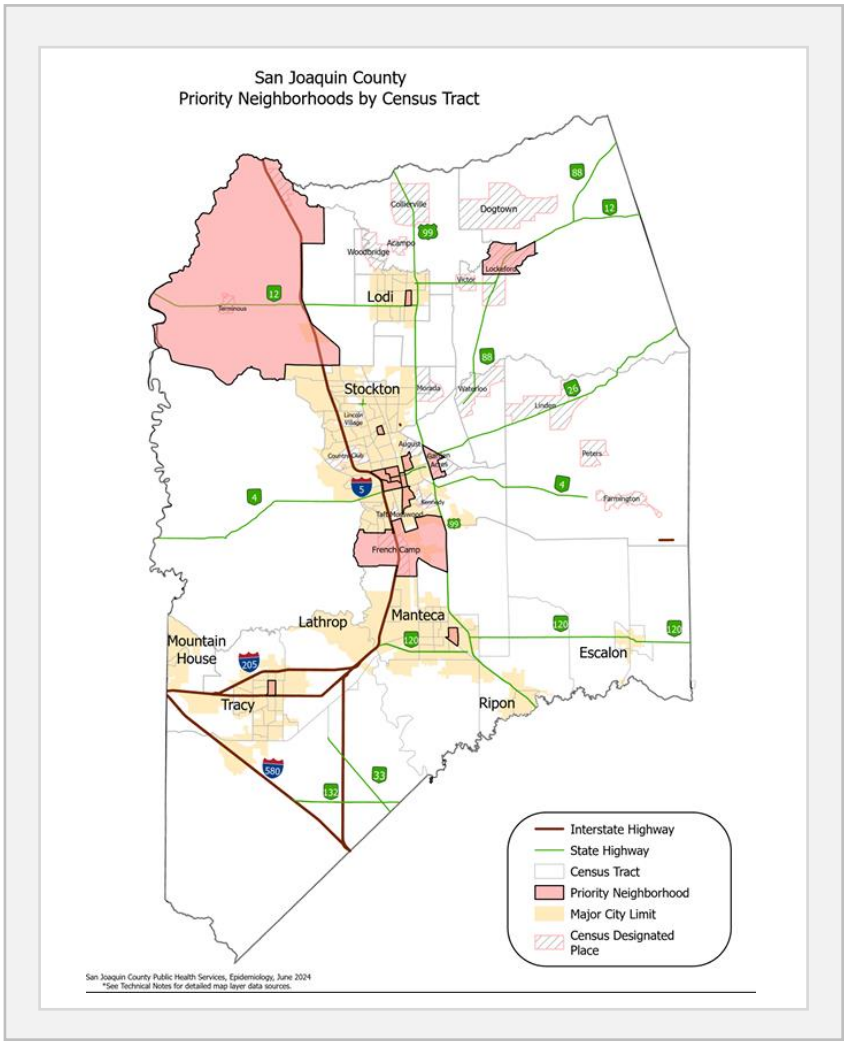
Table 6 lists the 14 San Joaquin County Priority Neighborhoods. The residents of the Priority Neighborhoods are the most impacted by both historic health disparities and lack of infrastructure investment, based on the data analysis described above.

Table 6: San Joaquin County Priority Neighborhoods (Census Tracts)

Census Tract	City	Included in 2022 CHNA
1.01 and 1.02	Stockton	✓ (as CT1)
3	Stockton	✓
6	Stockton	✓
7	Stockton	✓
16	Stockton	✓
22.01	Stockton	✓
27.01	Stockton (Garden Acres)	✓
33.12	Stockton	✓
38.03	French Camp	✓
40.01	Thornton	✓
44.03	Lodi	✓
47.01	Lockeford	✓
51.09	Manteca	✓
53.03	Tracy	✓

The map in Figure 5 below shows where the Priority Neighborhoods are located. The CHNA includes 14 Priority Neighborhoods. Profiles of the Priority Neighborhoods (Census Tracts) are presented in Section VII.A. Each Priority Neighborhood's profile includes the following: map of the census tract, demographic data, root causes of health, and birth and death statistics. For each of the data points, the change since the 2022 CHNA is described.

Figure 5. Map of 14 Priority Neighborhoods



VI. Identification and Prioritization of the Community's Health Needs

A. Identifying Community Health Needs

i. Definition of "Health Need"

Community-wide health needs represent the greatest challenges faced by County residents around maximizing health and well-being. For the purposes of the CHNA, health needs are defined as including requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). Requisites may include addressing financial and other barriers to care as well as preventing illness; ensuring adequate nutrition; or addressing social, behavioral, and environmental factors that influence health in the community. Health needs were identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

The following criteria were used:

- It fits the definition of a "health need" as described above.
- It was confirmed by multiple data sources (i.e., identified in both secondary and primary data).
- Indicator(s) related to the health need performed statistically significantly worse than the state average.
- It was chosen as a community priority based on the frequency with which key informants and focus groups mentioned the need. The final list included only those that informants and focus groups identified as a priority need.

The following methods were used:

- A health needs identification table was developed which included all related indicators that benchmarked statistically significantly worse than the state. Race and ethnicity data were reviewed (when available) to identify all indicators for which disparities existed. The number of groups experiencing disparities for a given indicator was noted and addressed during prioritization. Primary data were reviewed and assessed for overall priority of health issues, racial/ethnic disparities, geographic disparities and disparities affecting other groups.
- While Cancer, Climate and Environment, and Sexual Health each had several indicators that performed poorly against the state average, they were not included as health needs for the CHNA because they were not mentioned with frequency in the primary data collection.

Ten health needs met the above criteria:

Highest Priority
Access to care
Mental health including substance use
Chronic disease/Healthy Eating, Active Living (HEAL)
Medium Priority
Housing
Economics
Social support
Lower Priority
Community safety (tied with Education)
Education
Food security (tied with Transportation)
Transportation

All of these health needs are interrelated and affect each other, and it is often necessary to address lower-priority and additional needs in order to improve the higher-priority needs on an individual and/or community level. This list is useful for revealing the most pressing needs of San Joaquin County residents and framing future investments by health systems and policymakers.

B. Criteria and Process Used for Prioritization of Health Needs

i. Prioritization Criteria

The following criteria were identified to use in prioritizing the list of health needs:

- Health measures: San Joaquin County indicators compare poorly to the California average.
- Clear disparities or inequities: Data show differences by racial/ethnic subgroups.
- Community input: Interviews/focus groups identified important issues related to the health need.

- Prevention: Opportunities exist for health promotion and disease prevention rather than treatment.

ii. Prioritization Process

After points were assigned to each health need for the above criteria, scores were totaled for the health needs (Sections IV.A.ii and IV.B.ii describe the process of assigning points to the secondary data and primary data, respectively). Scores for health need rankings from the 2022 CHNA and CHIP processes were also factored into the overall health need scores. The scores for the 15 health needs were then normalized to a 100 point scale, producing a list of the health needs in rank order.

The CHNA assessment findings and health need prioritization were presented at three community meetings. Meeting attendees provided input and concurred that each of the health needs was important and that these issues are interrelated.

C. Prioritized Description of Health Needs Identified through the CHNA

See Section VII.B. for the ten complete Health Needs Profiles. The paragraphs below summarize their content.

Highest Priority

- **Access to care**: Access to comprehensive, quality healthcare is important for health and for increasing and maintaining a high quality of life. In San Joaquin County, residents have access to significantly fewer health care providers (including mental health providers) than the California average, which contributes long wait time for appointments, limited clinic hours, the need to travel for specialty care, and frustration with and distrust of the medical system. Lack of prenatal care and lower rates of health insurance, especially among women of color, can be linked to the higher percentage of poor outcomes for infants. Key informants and focus group participants emphasized the need for culturally and linguistically competent providers, as well as assistance with insurance applications and other healthcare paperwork. Many key informants and focus group participants noted the success of pop-up and mobile COVID-19 vaccination and testing clinics established in partnership with community-based organizations, which created access points for other health care services in underserved areas; they suggested that this model be maintained and expanded to address a variety of health needs.
- **Mental health including substance use:** Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school, and to participate fully in family and community activities. Residents of San Joaquin County have a higher rate of deaths by suicide, drug overdose, and alcohol poisoning combined than the California average, with significantly fewer

mental health providers available. Participants of almost two-thirds of the focus groups described mental health as the number one health issue within their communities, and, along with key informants, expressed particular concern for children's mental health and the associated increase in drug, alcohol, and vaping use among children and teens. Key informants and focus group participants pointed out the intersection of mental health needs, substance use, and homelessness, and stressed the urgent necessity for diverse providers, timely crisis intervention services, improved access to mental health care in rural areas, and services tailored to the needs of underserved groups.

- **Chronic disease/Healthy Eating, Active Living (HEAL):** Chronic diseases are a primary cause of poor health outcomes and death and a leading driver of health care costs. The rates of diabetes and obesity among adults in San Joaquin County are higher than California overall, as are the rates of heart disease and stroke deaths. Black/African American County residents have the highest rates of diabetes, pediatric asthma prevalence, hospitalizations for cardiovascular disease, and the highest incidence of colorectal and lung cancer among all ethnicities/races. Focus group participants and key informants ascribed high chronic disease rates to the pervasive presence of unhealthy processed/fast foods, lack of affordable healthy foods, food deserts, community barriers to physical activity, and limited access to healthcare. These are especially present in communities/neighborhoods with a high percentage of low-income residents, people of color, and immigrants.

Medium Priority

- **Housing:** Stable, affordable housing is strongly associated with health, well-being, educational achievement, and economic success. Housing stability and housing cost burden are especially important factors for both health and economic stability. When compared to California overall, indicators of housing instability in San Joaquin County are better than state averages. However, countywide rental and mortgage costs have substantially increased, and secondary data indicates that disparities exist for residents of color and residents of the Priority Neighborhoods related to homeownership and crowded housing. Focus group participants and key informants agreed that the lack of affordable housing in the county is severe, with high housing costs contributing to stress and reducing available financial resources for health needs. They described homelessness as a significant problem in the county, in part because many unhoused individuals require additional services, treatments and/or rehabilitation programming that are not sufficiently available to meet demand. Low- and middle-income residents (especially people of color, immigrants, migrants, older adults, people with special needs, urban residents, and

single parents) are most impacted by rising housing costs, and struggle to obtain housing assistance and services tailored to meet their specific needs.

- **Economics**: People with steady employment are less likely to have an income below the poverty level and more likely to be healthy. San Joaquin County's higher unemployment, lower average income, pervasive poverty, and variable access to high-speed Internet, especially among people of color, may affect opportunities and behaviors that exacerbate chronic disease and disability, reduce food security, limit healthy food and physical activity choices, erode mental health, and impact substance use. Focus group participants and key informants stated that obtaining employment or regaining economic stability has been difficult after pandemic-related job losses, especially for middle-income residents who now find themselves struggling with expenses but not able to qualify for assistance and services. People of color, older adults, and unhoused individuals experience disparities in employment resulting in lower incomes that negatively impact health.
- **Social support:** The presence or absence of a strong social support network affects all aspects of life, including physical and mental well-being. Communities are the context in which families prosper or struggle, highlighting the importance of identifying areas of need and disparity and leveraging community resources to address them. In San Joaquin County, racial/ethnic disparities are present among those with disabilities and many residents have limited English proficiency – both statuses for which social support can be essential for integrating into long-term stability, health, and economic success. Focus group participants and key informants perceived that residents (especially those in rural areas) require more support with caring for children, loved ones with disabilities, and older adults; more opportunities to combat loneliness and isolation; and more assistance for children aging out of foster care.

Lower Priority

- **Community Safety:** Safe communities promote community cohesion and economic development and provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Rates of violent crime, injury, motor vehicle accidents, and premature deaths are all higher in San Joaquin County than statewide. Focus group participants and key informants agreed that residents' perceived lack of community safety in public, outdoor spaces like parks limits the ability to be physically active, especially for children and older adults.
- **Education:** The link between education and health is well known—those with higher levels of education are more likely to be healthier and live longer. Fewer children in San Joaquin County are enrolled in preschool than statewide, which is

associated with academic readiness for kindergarten and long-term success. San Joaquin County students have lower rates of proficiency in math and reading than students across California, with evidence of significant disparities for Hispanic/Latino, Black/African American, and multiethnic students. Adults in the County are less likely to have a high school diploma or have completed a college degree. Focus group participants noted lasting pandemic impacts on education quality and outcomes, especially for students of color and those in underresourced schools, while key informants requested more support for career development and readiness at all educational levels.

- **Food security:** Many individuals and families struggle to consistently access the kinds of foods that support health and wellness. The percentage of San Joaquin County residents relying on SNAP to afford food is almost 50% higher than California overall, and more students qualify for free and reduced-price school lunches than the statewide average. Key informants and focus group participants reported that the need for food assistance is increasing due to post-pandemic economic impacts and resulting inflation.
- **Transportation:** Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing health care, and securing food. Secondary data indicates that County residents are less likely to engage in active transportation, such as biking or walking, and are more likely to commute alone by car. Focus group participants and key informants agreed that San Joaquin County residents experience challenges related to transportation, substantially impacting decisions related to healthcare, housing, and nutrition, and potentially leading to poor physical and mental health.

D. Community Resources Potentially Available to Respond to the Identified Health Needs

San Joaquin County's community-based organizations, public agencies, hospitals and clinics, and other entities are engaged in addressing many of the health needs identified by this assessment. Key resources available to respond to the identified health needs of the County are listed in Appendix G Community Resources.

VII. Profiles

A. Priority Neighborhood Profiles

PRIORITY NEIGHBORHOOD PROFILE

Census Tracts 1.01 and 1.02

San Joaquin County Public Health Services, Epidemiology. 6/25/2024

Census tract (CT) description:

Since the 2022 community health needs assessment (CHNA), CT 1 has been divided into CTs 1.01 and 1.02. CT 1.01 is bordered by the following streets: Highway 4 in the north, S. El Dorado Street to the west, Hazelton on the south, and Union/Aurora on the east. CT 1.02 is bordered by Highway 4 in the south, Union/Aurora on the east, Park on the north, and Madison/El Dorado on the west. All data presented in this neighborhood profile combines the statistics for CTs 1.01 and 1.02 to attain stable rates and counts. This Priority Neighborhood is home to 3,662 people.

Demographics

The majority of this neighborhood's residents are Hispanic and between the ages of 25 and 64 years old. Since the 2022 CHNA, CTs 1.01/1.02 experienced demographic changes reflected by a substantial increase in the Asian population and a decrease in the Black/African American population, as well as a decrease in young people below 24 years old (Table 1).

How to read the tables that follow: This profile presents data for the CTs and San Joaquin County (SJC) and explores how these CTs changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CTs 1.01/1.02 vs SJC)

		CTs 1.01/1.02	Change Since 2022 CHNA	SJC
Total Population		3,662	↓	779,445
Race/Ethnicity	Asian	14%	↑↑↑	17%
	Black/African American	11%	↓↓	7%
	Hispanic	60%	↑↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	1%	↑	<1%
	White	10%	↓	29%
	Multiple Races	4%	↑	4%
Gender	Female	45%	↓	50%
	Male	55%	↑	50%
Age Group	0- 5 yrs	8%	↓	8%
	6- 17 yrs	11%	↓	19%
	18- 24 yrs	4%	↓↓	10%
	25- 44 yrs	36%	↑	27%
	45- 64 yrs	28%	↑	23%
	≥65 yrs	12%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

Compared to SJC as a whole, CTs 1.01/1.02 measure worse on access to care, economics, social support, education, food security, and housing conditions. The difference is substantial for income, and at least 10 percentage points worse than the County for percent insured, percent living in poverty, employment, two parent households, limited English proficiency, adults with no high school diploma, adults with a bachelor's level or higher education, SNAP enrollment, automobile access, housing habitability, and homeownership. Since the 2022 CHNA, this neighborhood has

improved on income, percent living in poverty, two parent households, preschool enrollment, adult educational attainment, automobile access, and homeownership. Performance has worsened for employment, limited English proficiency, SNAP Enrollment, active commuting, and housing habitability.

Table 2: Root Causes of Health (CTs 1.01/1.02 vs SJC)

Health Topic	Measure Name	CTs 1.01/1.02	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	81%	↓	91%
	Uninsured children (ages <19 yrs)	4%	↓	3%
Economic	Income	$25,464	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	42%	↓↓	13%
	Employed (ages 20- 64 yrs)	27%	↓↓	70%
Social Support	Two Parent Households	51%	↑↑	77%
	Limited English Proficiency	61%	↑↑↑↑	41%
Education	Preschool Enrollment	38%	↑	38%
	Adults (ages 25+ yrs) with no high school diploma	44%	↓	20%
	Bachelor's Education or Higher	8%	↑↑	20%
Food Security	Low Access to Grocery Stores	35%	—	28%
	SNAP Enrollment	38%	↑↑	15%
Transportation	Automobile Access	54%	↑	95%
	Active Commuting	8%	↓↓	3%
Built Environment	Retail Density	2%	—	<1%
	Urban Tree Canopy	10%	—	—
Housing	Housing Habitability	88%	↓	99%
	Homeownership	2%	↑↑	60%
Climate & Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

Although the % of CTs 1.01/1.02 residents living in poverty has decreased since the 2022 CHNA, the poverty rate is over three times higher than SJC overall.

SNAP (food assistance) enrollment, which has increased since the 2022 CHNA, is over double the SJC average, indicating that CTs 1.01/1.02 residents need financial assistance to meet basic needs, but are receiving support.

Homeownership is one element of housing and economic stability. Despite increasing since the 2022 CHNA, homeownership in CTs 1.0/1.02 remains very low and substantially lower than SJC overall.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with overall County rates, CTs 1.01/1.02 have a higher overall birth rate, and a higher percentage of teen births. There are fewer pregnant persons

receiving early prenatal care in these neighborhoods. Compared to the 2022 CHNA, there has been a decrease in babies born with low birth weights.

Table 3: Birth Outcomes (CTs 1.01/1.02 vs SJC)

Measure Name	CTs 1.01/1.02	Change Since 2022 CHNA	SJC
Pre-term births	10%	↓	9%
Low birth weight	8%	↓↓	8%
Prenatal care in 1st trimester	67%	↓	79%
Teen births (mothers ages 15- 19 yrs)	10%	↑	4%
Birth Rate			
Total	18	↓	13
Asian	9	↓↓	13
Black/African American	5	↓↓↓	12
Hispanic	20	↓	15
White	27	↑↑↑	8

Refer to technical notes for data sources.

In this neighborhood, Hispanic and Black/African American individuals are dying at a younger age than other racial/ethnic groups. The age- adjusted death rate in this neighborhood is well over double the overall County rate. In terms of leading causes of death, this neighborhood's rates of death from heart disease, COVID-19, unintentional injuries, and deaths of despair are more than twice as high as the County rate, and its rate of cancer deaths is also higher than the County average. The average age of death among Asian, Black/African American, and White residents has increased since the 2022 CHNA, while the average age of death among Hispanic residents has decreased.

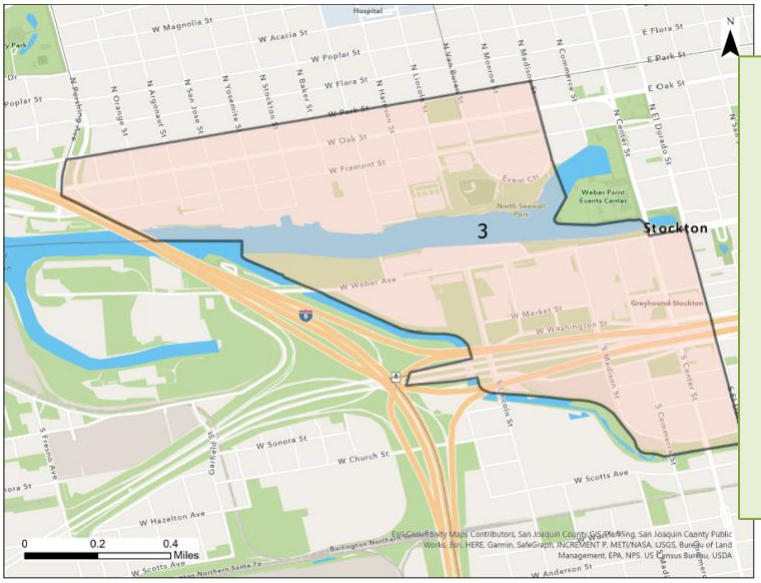
Table 4: Death Statistics (CTs 1.01/1.02 vs SJC)

Measure Name	CTs 1.01/1.02	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	69		77
Average Age of Death (yrs)			
Total	63	↑	71
Asian	68	↑	72
Black/African American	62	↑	64
Hispanic	62	↓	65
White	65	↑	75
Age-Adjusted Death Rate - Total	2,174	↑↑	832
Top 5 Causes of Death			
Heart disease deaths	493	↑↑↑	148
Cancer deaths	256	↑↑↑	144
COVID-19 deaths	200	↑	61
Unintentional injury deaths	131	↓↓	55
Deaths of despair	130	↓	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 3



Census tract (CT) description:

CT 3 in Stockton is bounded by the following streets: Madison/El Dorado on the east, Park on the north, Hazelton/Scotts on the south, and I-5 on the west. This Priority Neighborhood is home to 2,298 people.

San Joaquin County Public Health Services, Epidemiology. 6/25/2024

Demographics

The most prominent race/ethnicity living in this CT is Hispanic, followed by Black/African American; the CT has a higher percentage of females than males. Since the 2022 community health needs assessment (CHNA), CT 3 experienced an increase in the Black/African American and Multiple Race populations, and an increase in children under age five and between ages 18-24 (Table 1), while the population of adults aged 45-64 years has decreased.

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 3 vs SJC)

		CT 3	Change Since 2022 CHNA	SJC
Total Population		2,298	↑	779,445
Race/Ethnicity	Asian	11%	↓	17%

	Black/African American	25%	↑↑	7%
	Hispanic	44%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	16%	↑	29%
	Multiple Races	5%	↑↑↑↑	4%
Gender	Female	57%	↑	50%
	Male	43%	↓	50%
Age Group	0- 5 yrs	13%	↑↑	8%
	6- 17 yrs	12%	—	19%
	18- 24 yrs	12%	↑↑	10%
	25- 44 yrs	28%	↑	27%
	45- 64 yrs	16%	↓↓	23%
	≥65 yrs	19%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

Compared to the County overall, CT 3 performs worse on access to care, economics, social support, education, and food security. Income in CT 3 is less than a third of the County average income and substantial disparities (10 percentage points or worse) between CT 3 and SJC overall exist for: percent living in poverty, employment, two parent households, limited English proficiency, low access to grocery stores, SNAP enrollment, automobile access, and homeownership. This neighborhood performs better than the County on drought risk. Since the 2022 CHNA, this neighborhood has improved on measures of insurance coverage, income, adult educational attainment, automobile access, active commuting, and homeownership. However, percent living in poverty, employment, two parent households, limited English proficiency, preschool enrollment, and SNAP enrollment have worsened.

Table 2: Root Causes of Health (CT 3 vs SJC)

Health Topic	Measure Name	CT 3	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	87%	↑	91%
	Uninsured children (ages <19 yrs)	5%	↓↓	3%
Economic	**Income**	$24,223	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	45%	↑	13%
	Employed (ages 20- 64 yrs)	60%	↓	70%
Social Support	Two Parent Households	33%	↓↓	77%
	Limited English Proficiency	69%	↑↑↑↑↑	41%

Despite an increase in average income since the 2022 CHNA, the Income level in CT 3 is under a third of the SJC average income.

Education	Preschool Enrollment	32%	↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	20%	↓↓	20%
	Bachelor's Education or Higher	15%	↑↑↑	20%
Food Security	Low Access to Grocery Stores	56%	—	28%
	SNAP Enrollment	43%	↑	15%
Transportation	Automobile Access	70%	↑	95%
	Active Commuting	5%	↑	3%
Built Environment	Retail Density	2%	—	<1%
	Urban Tree Canopy	11%	—	—
Housing	Housing Habitability	100%	—	99%
	Homeownership	12%	↑↑	60%
Climate and Environment	Drought Risk	1	—	52
	Air pollution: PM2.5 concentration	12	—	15

The percentage of adults with higher education has increased substantially since the 2022 CHNA.

Food security in CT 3 is a concern; SNAP (food assistance) enrollment is almost triple the SJC average indicating that CT 3 residents require support to meet food needs.

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, this neighborhood has a higher overall birth rate, as well as higher birth rates among Black/African American and Hispanic residents. There are double the percentage of teen births in this neighborhood when compared to the County. Notable changes to birth rates since the 2022 CHNA include an increase for the Asian population and a decrease for the Black/African American and White populations.

Table 3: Birth Outcomes (CT 3 vs SJC)

Measure Name	CT 3	Change Since 2022 CHNA	SJC
Pre-term births	9%	↓	9%
Low birth weight	10%	↑	8%
Prenatal care in 1st trimester	72%	↓	79%
Teen birth rate (mothers ages 15- 19 yrs)	8%	↓	4%
Birth Rate			
Total	17	↓	13
Asian	7	↑↑	13
Black/African American	16	↓↓	12
Hispanic	22	↑	15
White	8	↓↓	8

Refer to technical notes for data sources.

In this neighborhood, White and Black/African American residents are dying at a younger age than the County average, and Black/African American residents are dying at a younger age than other racial/ethnic groups within this CT. The average age of death for all groups except the Asian population has increased since the 2022 CHNA. This neighborhood's rates of deaths due to unintentional injuries, despair, and cancer are at least double the County's rate. Rates for all five leading causes of death have decreased since the 2022 CHNA.

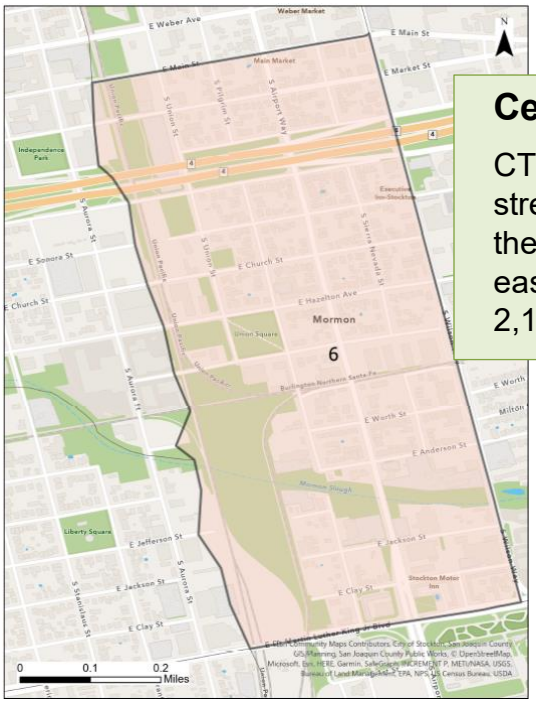
Table 4: Death Statistics (CT 3 vs SJC)

Measure Name	CT 3	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	70	—	77
Average Age of Death (yrs)			
Total	69	↑	71
Asian	84	↓	72
Black/African American	63	↑	64
Hispanic	68	↑	65
White	69	↑	75
Age- Adjusted Death Rate - Total	1,094	↓	832
Top 5 Causes of Death			
COVID-19 deaths	197	↓↓	148
Heart disease deaths	171	↓	144
Unintentional injury deaths	139	↓↓	55
Deaths of despair	111	↓	44
Cancer deaths	93	↓↓	144

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 6



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 6 in Stockton is bounded by the following streets: Union/Aurora on the west, Charter on the south, Main on the north, and Wilson on the east. This Priority Neighborhood is home to 2,171 people.

Demographics

Three-quarters of the neighborhood's residents are Hispanic and between the ages of 25 and 64. Demographic changes in CT 6 include an increase in the Black/African American population and a decrease in the White and Multiple Race populations since the 2022 community health needs assessment (CHNA). There was an increase in young adults aged 18-24 and older adults over 65 years, and a decrease in children under age 5 (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 6 vs SJC)

		CT 6	Change Since 2022 CHNA	SJC
Total Population		2,171	↑↑	779,445
Race/Ethnicity	Asian	11%	↓	17%
	Black/African American	9%	↑↑↑↑↑	7%
	Hispanic	75%	—	43%
	American Indian/Alaska Native	<1%	—	<1%

	Pacific Islander/Native Hawaiian	1%	—	<1%
	White	3%	↓↓	29%
	Multiple Races	1%	↓↓↓	4%
Gender	Female	49%	↑	50%
	Male	51%	↓	50%
Age Group	0- 5 yrs	7%	↓↓	8%
	6- 17 yrs	19%	↑	19%
	18- 24 yrs	15%	↑↑	10%
	25- 44 yrs	26%	↓	27%
	45- 64 yrs	24%	↑	23%
	≥65 yrs	10%	↑↑↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood has lower measures than the County for access to care, economics, social support, education, transportation, and housing conditions. Income in CT 6 is substantially lower than the County average and disparities (10 percentage points worse) are present in CT 6 for: percent with insurance coverage, percent living in poverty, preschool enrollment, adult educational attainment, SNAP enrollment, and homeownership. CT 6 fares better (10 percentage points or more) than SJC on access to grocery stores. Since the 2022 CHNA, CT 6 has improved on percent with insurance coverage, income, employment, adults without high school diplomas, automobile access, and housing habitability. However, the percent living in poverty, two parent households, limited English proficiency, adults with a bachelor's education or higher, SNAP enrollment, active commuting, and homeownership have worsened.

Table 2: Root Causes of Health (CT 6 vs SJC)

Health Topic	Measure Name	CT 6	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	69%	↑	91%
	Uninsured children (ages <19 yrs)	7%	↓↓	3%
Economic	Income	$31,853	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	36%	↑	13%
	Employed (ages 20- 64 yrs)	64%	↑	70%
Social Support	Two Parent Households	70%	↓	77%
	Limited English Proficiency	43%	↑	41%
Education	Preschool Enrollment	20%	↑↑	38%

Economic stability directly impacts residents' health and well-being. The poverty rate has slightly increased from the 2022 CHNA, and is now almost three times higher than that of SJC.

	Adults (ages 25+ yrs) with no high school diploma	53%	↓	20%
	Bachelor's Education or Higher	2%	↓	20%
Food Security	Low Access to Grocery Stores	12%	—	28%
	SNAP Enrollment	50%	↑↑↑↑	15%
Transportation	Automobile Access	92%	↑	95%
	Active Commuting	<1%	↓↓↓↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	10%	—	—
Housing	Housing Habitability	98%	↑	99%
	Homeownership	14%	↓	60%
Pollution	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Education attainment has a role in economic security long-term. Although there are more adults receiving high school diplomas since the 2022 CHNA, it is still considerably lower than the SJC average.

SNAP (food assistance) enrollment is more than triple the SJC average, indicating that CT 6 residents need financial assistance to meet basic needs, but that they are receiving support.

Birth and Death Statistics

When compared with the County, this neighborhood has higher birth rates across most racial/ethnic groups, with the highest rates seen among Hispanic and Asian residents. There are over double the rate of teen births and fewer pregnant persons receiving early prenatal care in CT 6 than the County overall. Since the 2022 CHNA, this neighborhood performs worse on babies born at low birth weight.

Table 3: Birth Outcomes (CT 6 vs SJC)

Measure Name	CT 6	Change Since 2022 CHNA	SJC
Pre-term births	8%	↓	9%
Low birth weight	6%	↑↑	8%
Prenatal care in 1st trimester	68%	↑	79%
Teen births (mothers ages 15- 19 yrs)	11%	↑	4%
Birth Rate			
Total	16	↓↓	13
Asian	16	↓	13
Black/African American	11	↓↓↓	12
Hispanic	16	↓↓	15
White	15	↑	8

Refer to technical notes for data sources.

In this neighborhood, all racial/ethnic groups have a lower average age of death than the County overall, with the Black/African American population experiencing the lowest average age of death despite improving since the 2022 CHNA. Among the top five causes of death in CT 6, the rate of death due to unintentional injuries is almost twice the County rate, while the rates of death due to COVID-19 and heart disease have decreased substantially since the 2022 CHNA.

Table 4: Death Statistics (CT 6 vs SJC)

Measure Name	CT 6	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	76	—	77
Average Age of Death (yrs)			
Total	61	↓	71
Asian	64	↓	72
Black/African American	58	↑	64
Hispanic	60	↓	65
White	61	↓	75
Age-Adjusted Death Rate - Total	1,051	↓↓	832
Top 5 Causes of Death			
COVID-19 deaths	157	↓↓↓	61
Cancer deaths	125	↓	144
Unintentional injury deaths	116	↑↑	55
Heart disease deaths	53	↓↓↓	148
Deaths of despair	51	↓	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 7

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 7 in Stockton is bounded by the following streets: I-5 on the west, Charter on the south, Hazelton/Scotts on the north, and Union/Aurora on the east. This Priority Neighborhood is home to 5,284 people.

Demographics

The majority of this neighborhood's residents are Hispanic and between the ages of 25 and 64. Since the 2022 community health needs assessment (CHNA), CT 7 has experienced demographic changes, including an increase in the Multiple Races population. The number of children under five has increased substantially since the 2022 CHNA, while the percentage of adults aged 45 and above has decreased in this neighborhood (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 7 vs SJC)

		CT 7	Change Since 2022 CHNA	SJC
Total Population		5,284	↑	779,445
Race/Ethnicity	Asian	13%	↓	17%
	Black/African American	7%	↓	7%
	Hispanic	70%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	7%	↓	29%
	Multiple Races	2%	↑↑	4%
Gender	Female	50%	↓	50%
	Male	50%	↑	50%
Age Group	0- 5 yrs	8%	↑↑↑↑	8%
	6- 17 yrs	18%	↑	19%
	18- 24 yrs	10%	↓	10%
	25- 44 yrs	30%	↑	27%
	45- 64 yrs	25%	↓	23%
	≥65 yrs	7%	↓↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood fares worse than the County as a whole on most topics, including access to care, economics, social support, education, and housing conditions. Income in this CT is about half the SJC average income and disparities (at least 10 percentage points worse than the County) are present for percent of insured adults, percent living in poverty, employment, limited English proficiency, adult educational attainment, SNAP enrollment, automobile access, and homeownership. CT 7 performs better (10 percentage points or more) than the County on measures of preschool enrollment and access to grocery stores. Since the 2022 CHNA, there have been improvements in income, employment, two parent households, preschool enrollment, adult educational attainment, SNAP enrollment, housing habitability, and homeownership. However, performance has worsened when it comes to the percentage of adults with insurance coverage, percent living in poverty, limited English proficiency, automobile access, and active commuting.

Table 2: Root Causes of Health (CT 7 vs SJC)

Health Topic	Measure Name	CT 7	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	75%	↓	91%
	Uninsured children (ages <19 yrs)	8%	—	3%
Economic	Income	$41,793	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	39%	↑	13%
	Employed (ages 20- 64 yrs)	55%	↑	70%
Social Support	Two Parent Households	74%	↑	77%
	Limited English Proficiency	53%	↑↑↑	41%
Education	Preschool Enrollment	52%	↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	46%	↓	20%
	Bachelor's Education or Higher	8%	↑↑↑	20%
Food Security	Low Access to Grocery Stores	5%	—	28%
	SNAP Enrollment	27%	↓	15%
Transportation	Automobile Access	84%	↓	95%
	Active Commuting	3%	↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	12%	—	—
Housing	Housing Habitability	100%	↑	99%
	Homeownership	45%	↑↑	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Income and poverty directly impact residents' health and well-being; the percent of individuals living in poverty in CT 7 is triple the SJC poverty rate.

Adults pursuing a bachelor's education or higher increased since the 2022 CHNA but is lower than SJC overall.

SNAP (food assistance) enrollment is close to double the SJC average, indicating that CT 7 residents need financial assistance to meet basic needs, but that they are receiving support.

Birth and Death Statistics

When compared with the County, CT 7 has double the rate of teen births. The rate of pre-term births has decreased in this neighborhood since the 2022 CHNA. While the overall birth rate is higher than the County rate, this neighborhood has lower birth rates among Asian and Black/African American residents when compared to the County.

Table 3: Birth Outcomes (CT 7 vs SJC)

Measure Name	CT 7	Change Since 2022 CHNA	SJC
Pre-term births	10%	↓↓	9%
Low birth weight	10%	↓	8%

Prenatal care in 1st trimester	71%	↓	79%
Teen births (mothers ages 15- 19 yrs)	8%	↓	4%
Birth Rate			
Total	17	↓	13
Asian	8	↓↓	13
Black	10	↓	12
Hispanic	19	↓	15
White	8	↓	8

Refer to technical notes for data sources.

In this neighborhood, Black/African American and Hispanic residents are dying younger than other racial/ethnic groups. Since the 2022 CHNA, the average age of death for all groups, excluding Asian residents, has decreased. This neighborhood's rates of death due to heart disease, cancer, unintentional injuries, despair and COVID-19 are higher than the County rates. There has been a substantial increase in the rate of deaths due to cancer and a decrease in the rate of deaths due to COVID-19 since the 2022 CHNA.

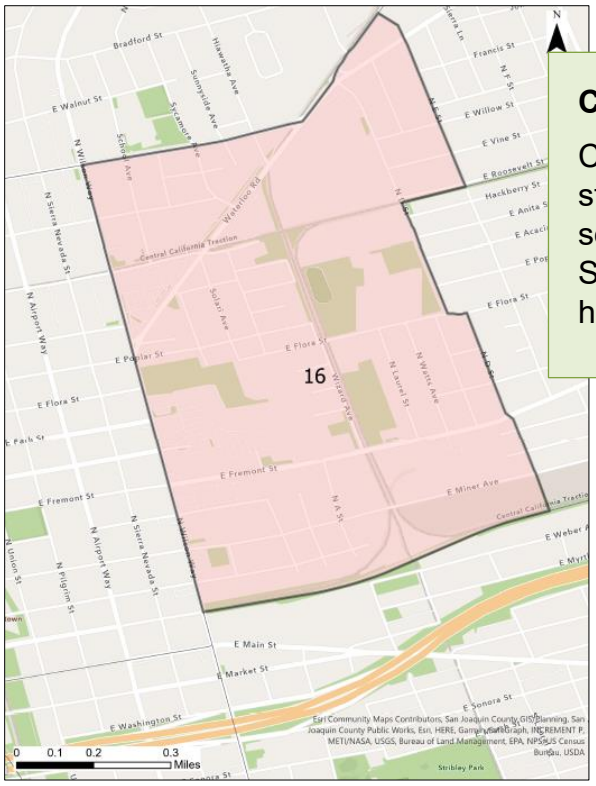
Table 4: Death Statistics (CT 7 vs SJC)

Measure Name	CT 7	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	71	—	77
Average Age of Death (yrs)			
Total	62	↓	71
Asian	79	↑	72
Black	57	↓	64
Hispanic	57	↓	65
White	61	↓	75
Age-Adjusted Death Rate - Total	1,343	↑	832
Top 5 Causes of Death			
Heart disease deaths	218	↑	148
Cancer deaths	182	↑↑↑	144
Unintentional injury deaths	160	↑	55
Deaths of despair	125	↑	44
COVID-19 deaths	103	↓↓	61

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 16



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 16 in Stockton is bounded by the following streets: Wilson on the west, Weber/Miner on the south, Harding/Cherokee on the north, and D/E St. on the east. This Priority Neighborhood is home to 2,494 people.

Demographics

The majority of this neighborhood's residents are Hispanic and between the ages of 0-24. This neighborhood has seen demographic change since the 2022 community health needs assessment (CHNA), including a decrease in the Asian, Black/African American, and White populations (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 16 vs SJC)

		CT 16	Change Since 2022 CHNA	SJC
Total Population		2,494	↑	779,445
Race/Ethnicity	Asian	2%	↓↓↓	17%
	Black	3%	↓↓	7%
	Hispanic	74%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%

	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	15%	↓↓	29%
	Multiple Races	6%	—	4%
Gender	Female	47%	↑	50%
	Male	53%	↓	50%
Age	0- 5	4%	↓↓	8%
	6- 17	33%	↑	19%
	18- 24	14%	↑↑↑↑↑	10%
	25- 44	25%	↓	27%
	45- 64	19%	↓	23%
	≥65	6%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This Priority Neighborhood fares worse than the County overall across economics, education and transportation. Income in this CT is two thirds that of the SJC average income, and disparities (at least 10 percentage points worse than SJC) are present for percent living in poverty, adults with bachelor's education or higher, SNAP enrollment, and homeownership. In contrast, this neighborhood performs better than the County (10 percentage points or more) on preschool enrollment. Since the 2022 CHNA, this neighborhood performs better on uninsured children, income, employment, preschool enrollment, adult educational attainment, automobile access, housing habitability, and homeownership, but worse on the percent living in poverty, two parent households, limited English proficiency, SNAP enrollment, and active commuting.

Table 2: Root Causes of Health (CT 16 vs SJC)

Health Topic	Measure Name	CT 16	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	89%	—	91%
	Uninsured children (ages <19 yrs)	3%	↓	3%
Economic	Income	$54,653	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	28%	↑	13%
	Employed (ages 20- 64 yrs)	71%	↑↑	70%
Social Support	Two Parent Households	74%	↓	77%
	Limited English Proficiency	39%	↑↑↑↑	41%
Education	**Preschool Enrollment**	66%	↑	38%
	Adults (ages 25+ yrs) with no high school diploma	28%	↓↓	20%
	Bachelor's Education or Higher	5%	↑	20%

Economic stability directly impacts residents' health and well-being. Employment in CT 16 has substantially improved since the 2022 CHNA.

Preschool enrollment has increased since the 2022 CHNA and is substantially greater than the SJC average.

Food Security	Low Access to Grocery Stores	—	—	28%
	SNAP Enrollment	45%	↑↑↑	15%
Transportation	Automobile Access	93%	↑	95%
	Active Commuting	2%	↓↓↓	3%
Built Environment	Retail Density	3%	—	<1%
	Urban Tree Canopy	7%	—	—
Housing	Housing Habitability	100%	↑	99%
	Homeownership	38%	↑	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	12	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Enrollment in SNAP (food assistance) is triple the SJC average and has increased substantially since the 2022 CHNA, indicating that individuals in CT 16 require support to meet basic needs.

Birth and Death Statistics

When compared to the County, this neighborhood has higher percentages of pre-term births, babies born at a low birth weight, and teen births, and fewer pregnant persons receiving early prenatal care. The birth rate is also higher in this neighborhood when compared to the County. Since the 2022 CHNA, CT 16 has improved on teen births, pre-term births, and accessing early prenatal care, but low birth weights have increased. The birth rate among Asian and Black/African American residents has substantially increased.

Table 3: Birth Outcomes (CT 16 vs SJC)

Measure Name	CT 16	Change Since 2022 CHNA	SJC
Pre-term births	11%	↓	9%
Low birth weight	11%	↑↑	8%
Prenatal care in 1st trimester	74%	↑	79%
Teen births (mothers ages 15- 19 yrs)	6%	↓	4%
Birth Rate			
Total	17	↓	13
Asian	30	↑↑↑↑↑	13
Black	26	↑↑↑↑↑	12
Hispanic	17	↓	15
White	10	↑	8

Refer to technical notes for data sources.

When compared to SJC overall, Asian, Hispanic, and White CT 16 residents are dying at a younger age, and the total age adjusted death rate is more than twice the County

rate. Compared to the 2022 CHNA, the average age of death for all groups combined has decreased while the average age of death for individual racial/ethnic groups have increased. Among the leading causes of death in this neighborhood, the rates of deaths due to cancer, heart disease, COVID-19, Alzheimer's, and unintentional injuries are higher than the County. While deaths due to COVID-19 have decreased, the rates of death due to cancer and Alzheimer's have more than doubled since the 2022 CHNA.

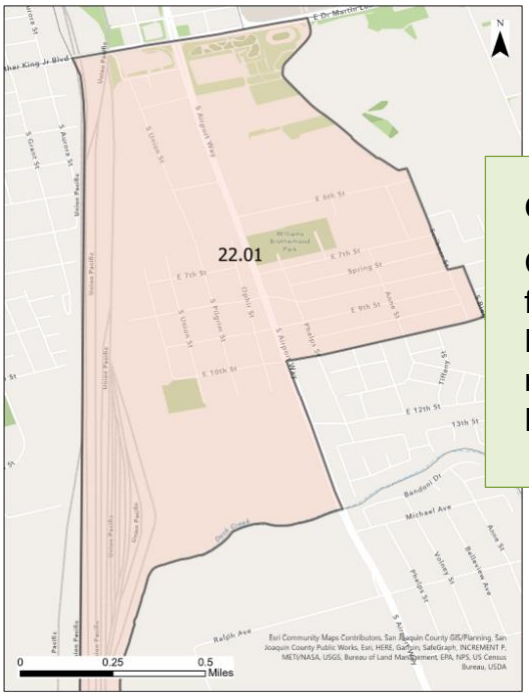
Table 4: Death Statistics (CT 16 vs SJC)

Measure Name	CT 16	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	73	—	77
Average Age of Death (yrs)			
Total	64	↓	71
Asian	59	↑↑	72
Black/African American	73	↑	64
Hispanic	63	↑	65
White	68	↑	75
Age-Adjusted Death Rate - Total	1,942	↑↑	832
Top 5 Causes of Death			
Cancer deaths	264	↑↑↑↑↑	144
Heart disease deaths	253	↑↑↑	148
COVID-19 deaths	172	↓	61
Alzheimer's deaths	155	↑↑↑↑↑	35
Unintentional injury deaths	115	↑	55

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 22.01



Census tract (CT) description:

CT 22.01 in Stockton is bounded by the following streets: Union/Aurora on the west, Duck Creek Levee on the south, Charter on the north, and Scribner/Bieghle on the east. This Priority Neighborhood is home to 3,564 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

The majority of this neighborhood's residents are Hispanic. The neighborhood population is young, with 52% age 24 or younger. The population aged 25-64 has decreased since the 2022 community health needs assessment (CHNA), while all other age groups have increased. Additionally, CT 22.01 experienced demographic changes reflected by a substantial decrease in the Asian and Multiple Race Populations (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 22.01 vs SJC)

		CT 22.01	Change Since 2022 CHNA	SJC
Total Population		3,564	↑	779,445
Race/Ethnicity	Asian	<1%	↓↓↓	17%
	Black/African American	18%	↑	7%
	Hispanic	78%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	2%	↓↓	29%
	Multiple Races	1%	↓↓↓	4%
Gender	Female	52%	↓	50%
	Male	48%	↑	50%
Age Group	0- 5 yrs	13%	↑	8%
	6- 17 yrs	26%	↑	19%
	18- 24 yrs	13%	↑	10%
	25- 44 yrs	27%	↓	27%
	45- 64 yrs	15%	↓	23%
	≥65 yrs	7%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

CT 22.01 fares worse than the County overall on economics, social support, education, and housing conditions. Income in this CT is just over 40% of the average SJC income and disparities (at least 10 percentage points worse than SJC) are present for percent living in poverty, limited English proficiency, preschool enrollment, adult educational attainment, SNAP enrollment, automobile access, housing habitability, and homeownership. This neighborhood has a lower drought risk than the County overall. Since the 2022 CHNA, CT 22.01 has experienced improvements in percent of insured adults, income, percent living in poverty, employment, two parent households, adults without high school diplomas, active commuting, and homeownership. However, limited English proficiency, preschool enrollment, adults with a bachelor's education or higher, SNAP enrollment, automobile access, and housing habitability have worsened.

Table 2: Root Causes of Health (CT 22.01 vs SJC)

Health Topic	Measure Name	CT 22.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	90%	↑	91%
	Uninsured children (ages <19 yrs)	<1%	—	3%
Economic	Income	$34,588	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	31%	↓	13%
	Employed (ages 20- 64 yrs)	61%	↑	70%
Social Support	Two Parent Households	71%	↑	77%
	Limited English Proficiency	51%	↑↑↑↑	41%
Education	Preschool Enrollment	23%	↓	38%
	Adults (ages 25+ yrs) with no high school diploma	45%	↓	20%
	Bachelor's Education or Higher	4%	↓	20%
Food Security	Low Access to Grocery Stores	27%	—	28%
	SNAP Enrollment	40%	↑	15%
Transportation	Automobile Access	81%	↓	95%
	Active Commuting	8%	↑↑↑	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	8%	—	—
Housing	Housing Habitability	87%	↓	99%
	Homeownership	42%	↑	60%
Climate and Environment	Drought Risk	3	—	52
	Air pollution: PM2.5 concentration	12	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Economic stability directly impacts residents' health and well-being. Although poverty has decreased since the 2022 CHNA, CT 22.01 has a poverty rate more than double the SJC average.

Limited English proficiency can impact ability to access health care and other services. The % of CT 22.01 residents with limited English increased substantially since the 2022 CHNA and is higher than SJC overall.

The % of adults without a high school diploma in CT 22.01 is over double the % for SJC, but has decreased since the 2022 CHNA.

Birth and Death Statistics

When compared with the County, this neighborhood has higher birth rates for all racial/ethnic groups combined. The birth rate among Asian residents has substantially increased since the 2022 CHNA, while the rate among Black/African American, Hispanic, and White residents has decreased. CT 22.01 performs worse than the County when it comes to pre-term births, babies born at a low birth weight, early prenatal care, and teen births. Since the 2022 CHNA, this neighborhood has seen a

decrease in teen births and pre-term births as well as a decrease in mothers receiving early prenatal care. The percentage of babies born at a low birth rate increased.

Table 3: Birth Outcomes (CT 22.01 vs SJC)

Measure Name	CT 22.01	Change Since 2022 CHNA	SJC
Pre-term births	11%	↓↓	9%
Low birth weight	11%	↑	8%
Prenatal care in 1st trimester	69%	↓	79%
Teen births (mothers ages 15- 19 yrs)	7%	↓↓	4%
Birth Rate			
Total	16	↓	13
Asian	42	↑↑↑↑↑	13
Black/African American	10	↓↓	12
Hispanic	16	↓	15
White	19	↓	8

Refer to technical notes for data sources.

This neighborhood's average age of death for all racial/ethnic groups except Hispanic is higher than the County average and has increased since the 2022 CHNA. The age adjusted death rate for all groups is 68% higher than the County average. For the top five causes of death, the rates of cancer, COVID-19, heart disease, stroke, and diabetes are considerably higher than the County rates. Compared to the 2022 CHNA, rates of death due to cancer, COVID-19, and heart disease have decreased.

Table 4: Death Statistics (CT 22.01 vs SJC)

Measure Name	CT 22.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	73	—	77
Average Age of Death (yrs)			
Total	67	↑	71
Asian	76	↑↑	72
Black/African American	69	↑	64
Hispanic	66	↑	65
White	71	↑	75
Age-Adjusted Death Rate - Total	1,225	↓↓	832
Top 5 Causes of Death			
Cancer deaths	219	↓	144
COVID-19 deaths	206	↓↓	61
Heart disease deaths	118	↓↓	148
Stroke deaths	96	↑	50
Diabetes deaths	86	↑	30

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 27.01

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 27.01 in Stockton is bounded by the following streets: Highway 99 on the west, Main on the south, Stokes/Cardinal on the north, and Del Mar on the east. This Priority Neighborhood is home to 6,362 people.

Demographics

Over three-quarters of this neighborhood's residents are Hispanic and the majority are between the ages of 25 and 64 years old. Compared to the 2022 community health needs assessment (CHNA), the Asian population has increased and there has been a decrease in individuals between the ages of 18-64 years old (Table 1) and an increase in residents aged 65 years and older.

How to read the tables that follow: This profile presents data for the CT and the San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 27.01 vs SJC)

		CT 27.01	Change Since 2022 CHNA	SJC
Total Population		6,362	↑	779,445
Race/Ethnicity	Asian	3%	↑↑↑	17%

	Black/African American	2%	↓	7%
	Hispanic	81%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	14%	↓	29%
	Multiple Races	1%	—	4%
Gender	Female	49%	↑	50%
	Male	51%	↓	50%
Age Group	0- 5 yrs	10%	↑	8%
	6- 17 yrs	10%	—	19%
	18- 24 yrs	8%	↓↓	10%
	25- 44 yrs	31%	↓	27%
	45- 64 yrs	22%	↓	23%
	≥65 yrs	10%	↑↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

In comparison with the County, CT 27.01 fares worse across access to care, economics, education, and housing. Income in this CT is two thirds of the SJC average income and disparities (10 or more percentage points worse than the County) are present for limited English proficiency, adult educational attainment, and SNAP enrollment. In contrast, this neighborhood performs better than the County (10 percentage points or more) on measures of preschool enrollment and drought risk. The percent insured adults, income, the percent living in poverty, employment, two parent households, preschool enrollment, adult educational attainment, automobile access, and homeownership have improved since the 2022 CHNA, while uninsured children, limited English proficiency, SNAP enrollment, active commuting, and housing habitability have worsened.

Table 2: Root Causes of Health (CT 27.01 vs SJC)

Health Topic	Measure Name	CT 27.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	82%	↑	91%
	Uninsured children (ages <19 yrs)	5%	↑	3%
Economic	**Income**	$54,338	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	15%	↓↓	13%
	Employed (ages 20- 64 yrs)	64%	↑	70%
Social Support	Two Parent Households	85%	↑	77%
	Limited English Proficiency	51%	↑↑↑↑	41%

Income directly impacts residents' health and well-being; although it has increased from the 2022 CHNA, the average income in CT 27.01 is still a third less than that of SJC.

Education	Preschool Enrollment	49%	↑↑↑↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	49%	↓	20%
	Bachelor's Education or Higher	5%	↑↑↑	20%
Food Security	Low Access to Grocery Stores	26%	—	28%
	SNAP Enrollment	44%	↑↑	15%
Transportation	Automobile Access	96%	↑	95%
	Active Commuting	1%	↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	10%	—	—
Housing	Housing Habitability	92%	↓	99%
	Homeownership	53%	↑	60%
Climate and Environment	Drought Risk	4	—	52
	Air pollution: PM2.5 concentration	11	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

The % of adults without a high school diploma in CT 27.01 is over double the % for SJC, but has decreased since the 2022 CHNA

SNAP (food assistance) enrollment is close to triple the SJC average, indicating that CT 27.01 residents need financial assistance to meet basic needs, but that they are receiving support.

Birth and Death Statistics

When compared with the County, CT 27.01 has a higher overall birth rate across all racial/ethnic groups. There are slightly more pre-term births, fewer pregnant persons receiving prenatal care during the first trimester, and more teen births compared to the County. However, there are fewer babies born with a low birth weight compared to the County.

Table 3: Birth Outcomes (CT 27.01 vs SJC)

Measure Name	CT 27.01	Change Since 2022 CHNA	SJC
Pre-term births	10%	↑	9%
Low birth weight	6%	↑	8%
Prenatal care in 1st trimester	75%	↓	79%
Teen births (mothers ages 15- 19 yrs)	6%	↓↓	4%
Birth Rate			
Total	17	↓	13
Asian	16	↓↓↓	13
Black/African American	18	↑↑↑↑↑	12
Hispanic	17	↓	15
White	9	↓	8

Refer to technical notes for data sources.

In this neighborhood, the average age of death across racial/ethnic groups is lower than the County average, except for the Asian population. The Hispanic population is dying at the youngest age in this neighborhood, followed by the Black/African American population. This neighborhood's rates of death due to heart disease, COVID-19, unintentional injuries, and despair are higher than the County's rates. Since the 2022 CHNA, rates of death due to heart disease, cancer, and COVID-19 have decreased, while the rates of death due to unintentional injuries and despair have increased.

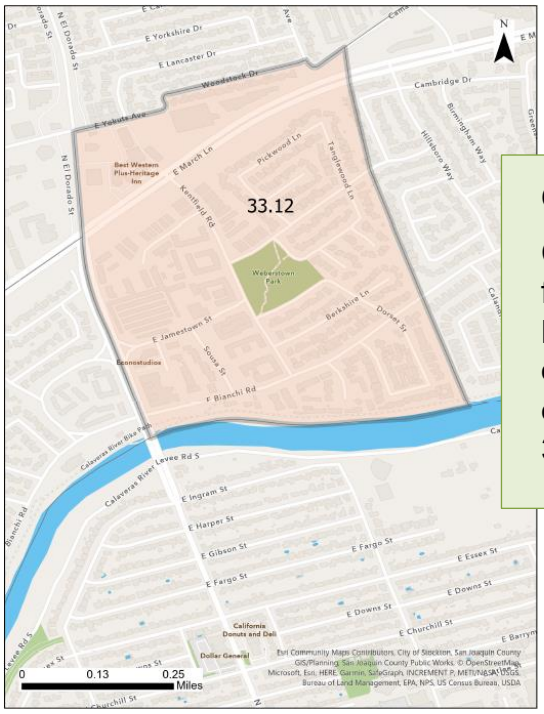
Table 4: Death Statistics (CT 27.01 vs SJC)

Measure Name	CT 27.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	76	—	77
Average Age of Death (yrs)			
Total	65	↑	71
Asian	76	↑	72
Black/African American	63	↑	64
Hispanic	62	—	65
White	69	↑	75
Age-Adjusted Death Rate - Total	1117	↓	832
Top 5 Causes of Death			
Heart disease deaths	188	↓↓	148
Cancer deaths	138	↓↓	144
COVID-19 deaths	101	↓↓	61
Unintentional injury deaths	81	↑↑	55
Deaths of despair	67	↑↑↑	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 33.12



Census tract (CT) description:

CT 33.12 in Stockton is bounded by the following streets: El Dorado on the west, Bianchi on the south, Woodstock/Camanache on the north, and Colebrook/Burnham on the east. This Priority Neighborhood is home to 3,095 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

Just under half of the residents in CT 33.12 are Hispanic and almost one third are Black/African American. The largest portion of residents are between the ages of 25 and 64 years old; there has been an increase in the 18-24 year old population as compared with the 2022 community health needs assessment (CHNA) (Table 1).

How to read the tables that follow: This profile presents data for the CT and the San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 33.12 vs SJC)

	CT 33.12	Change Since 2022 CHNA	SJC
Total Population	3,095	—	779,445

Race/Ethnicity	Asian	12%	↓	17%
	Black/African American	30%	↑	7%
	Hispanic	43%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	9%	—	29%
	Multiple Races	6%	↑↑↑	4%
Gender	Female	54%	↑	50%
	Male	46%	↓	50%
Age Group	0- 5 yrs	12%	↑	8%
	6- 17 yrs	19%	↓	19%
	18- 24 yrs	14%	↑↑	10%
	25- 44 yrs	26%	↓	27%
	45- 64 yrs	20%	↑	23%
	≥65 yrs	9%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

CT 33.12 performs worse than the County on economics, social support, and education. Income in this CT is substantially lower than the SJC average and disparities (at least 10 percentage points worse than SJC) are present for percent living in poverty, employment, two parent households, preschool enrollment, adults with a bachelor's education or higher, SNAP enrollment, automobile access, and homeownership. In contrast, this neighborhood performed better (10 percentage points or more) than the County on access to grocery stores. Since the 2022 CHNA, CT 33.12 performance has improved for the percent of insured adults, income, percent living in poverty, adults without high school diplomas, and active commuting. However, it has worsened for employment, two parent households, limited English proficiency, preschool enrollment, adults with a bachelor's education or higher, SNAP enrollment, automobile access, housing habitability, and homeownership.

Table 2: Root Causes of Health (CT 33.12 vs SJC)

Health Topic	Measure Name	CT 33.12	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	91%	↑	91%
	Uninsured children (ages <19 yrs)	<1%	—	3%
Economic	**Income**	$32,400	↑	$82,837

Income is a key element of economic stability, which directly impacts well-being. Income in CT 33.12 has increased since the 2022 CHNA but is less than half

	Living in poverty (<100% Federal Poverty Level)	32%	↓	13%
	Employed (ages 20- 64 yrs)	58%	↓	70%
Social Support	Two Parent Households	51%	↓	77%
	Limited English Proficiency	44%	↑↑↑↑	41%
Education	**Preschool Enrollment**	12%	↓↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	29%	↓	20%
	Bachelor's Education or Higher	6%	↓↓	20%
Food Security	Low Access to Grocery Stores	<1%	—	28%
	SNAP Enrollment	51%	↑	15%
Transportation	Automobile Access	79%	↓	95%
	Active Commuting	5%	↑↑↑↑↑	3%
Built Environment	Retail Density	1%	—	<1%
	Urban Tree Canopy	16%	—	—
Housing	Housing Habitability	99%	↓	99%
	Homeownership	10%	↓	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	11	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Preschool attendance positively impacts children's social and emotional development. Preschool enrollment dropped substantially since the 2022 CHNA and is much lower than SJC overall.

Over half of CT 33.12 residents are enrolled in SNAP (food assistance), pointing to a high level of food insecurity.

Birth and Death Statistics

When compared with the County, CT 33.12 has higher birth rates among Black/African American, Hispanic, and White residents. This neighborhood has more preterm births and teen births, and fewer pregnant persons receiving early prenatal care. In comparison to the 2022 CHNA, this neighborhood has seen a reduction in early prenatal care and teen births, and experienced an increase in pre-term births and babies born with low birth weight.

Table 3: Birth Outcomes (CT 33.12 vs SJC)

Measure Name	CT 33.12	Change Since 2022 CHNA	SJC
Pre-term births	11%	↑	9%
Low birth weight	8%	↑	8%
Prenatal care in 1st trimester	69%	↓	79%
Teen births (mothers ages 15- 19 yrs)	8%	↓	4%
Birth Rate			

Total	20	↑	13
Asian	10	↓	13
Black/African American	15	↓	12
Hispanic	23	↑	15
White	13	↓	8

Refer to technical notes for data sources.

In this neighborhood, the Hispanic population is dying at a younger age than any other racial/ethnic group, followed closely by the Black/African American population. The CT 33.12 average age of death for all groups combined is lower than the County's average and has decreased since the 2022 CHNA, except for the Asian population. The age adjusted death rate is higher in this neighborhood than the overall County rate. The top 5 causes of death for this neighborhood – heart disease, cancer, COVID-19, stroke, and Alzheimer's – are almost all double or more than the County's rates. Compared with the previous CHNA, the rates of death due to COVID-19 and stroke have declined while the rates of death due to cancer and Alzheimer's have increased.

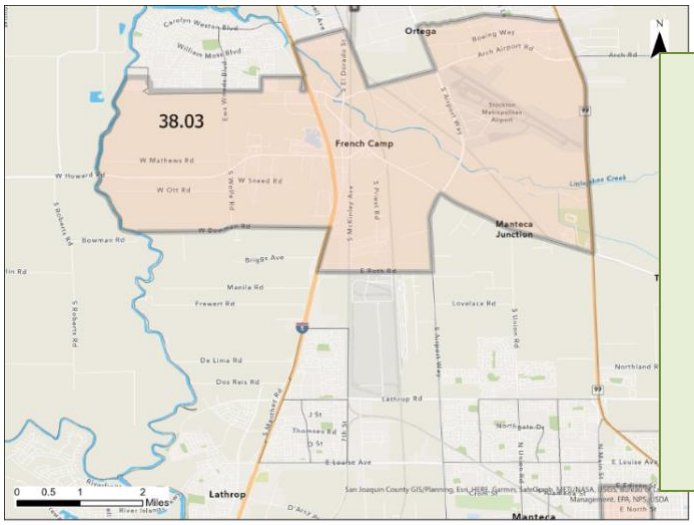
Table 4: Death Statistics (CT 33.12 vs SJC)

Measure Name	CT 33.12	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	66	—	77
Average Age of Death (yrs)			
Total	65	↓	71
Asian	70	↑	72
Black/African American	60	↓	64
Hispanic	58	↓	65
White	70	—	75
Age-Adjusted Death Rate - Total	1,861	↓	832
Top 5 Causes of Death			
Heart disease deaths	421	—	148
Cancer deaths	223	↑↑	144
COVID-19 deaths	167	↓↓↓	61
Stroke deaths	145	↓	50
Alzheimer's deaths	143	↑	35

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 38.03



Census tract (CT) description:

CT 38.03 is in the unincorporated community of French Camp and is bounded by the following streets: San Joaquin River on the west, Bowman and Roth on the south, French Camp on the north, and Highway 99 on the east. This Priority Neighborhood is home to 6,728 people.

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Demographics

This Census tract includes more residents than any other Priority Neighborhood, with more than three times the population of CT 6. The majority of this neighborhood's residents are Hispanic and between the ages of 25 and 64 years old. There is a higher percentage of males than females in this neighborhood compared to the County overall. Since the 2022 community health needs assessment (CHNA), CT 38.03 has experienced a decrease in a number of racial/ethnic populations, a decrease in residents 18-24 years old and an increase in children aged 6-17 (Table 1).

How to read the tables that follow: This profile presents data for the CT and the San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 38.03 vs SJC)

		CT 38.03	Change Since 2022 CHNA	SJC
Total Population		6,728	↑	779,445
Race/Ethnicity	Asian	8%	↓	17%
	Black/African American	9%	↓	7%
	Hispanic	59%	—	43%
	American Indian/Alaska Native	<1%	↓	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	20%	↑	29%
	Multiple Races	3%	↑↑↑	4%
Gender	Female	42%	↑	50%
	Male	58%	↓	50%
Age Group	0- 5 yrs	5%	↑	8%
	6- 17 yrs	14%	↑↑	19%
	18- 24 yrs	10%	↓↓	10%
	25- 44 yrs	36%	↓	27%
	45- 64 yrs	24%	↑	23%
	≥65 yrs	10%	—	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood performs worse than the County overall across economics, education, food security, and transportation. Disparities (at least 10 percentage points worse than the County) are present for the percent of insured adults, employment, limited English proficiency, adult educational attainment, low access to grocery stores, and SNAP enrollment. In contrast, this neighborhood has a higher average income than the County overall and performs better than the County on drought risk. Since the 2022 CHNA, income, employment, two parent households, and homeownership have improved, while the percent of insured adults, living in poverty, limited English proficiency, preschool enrollment, adult educational attainment, SNAP enrollment, active commuting, and housing habitability have all worsened.

Table 2: Root Causes of Health (CT 38.03 vs SJC)

Health Topic	Measure Name	CT 38.03	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	75%	↓	91%
	Uninsured children (ages <19 yrs)	<1%	—	3%

Economic	**Income**	$88,418	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	14%	↑↑	13%
	Employed (ages 20- 64 yrs)	56%	↑↑	70%
Social Support	Two Parent Households	84%	↑	77%
	Limited English Proficiency	54%	↑↑↑↑	41%
Education	Preschool Enrollment	38%	↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	38%	↑	20%
	Bachelor's Education or Higher	6%	↓↓	20%
Food Security	Low Access to Grocery Stores	39%	—	28%
	SNAP Enrollment	25%	↑↑↑↑↑	15%
Transportation	Automobile Access	91%	—	95%
	Active Commuting	2%	↓↓↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	5%	—	—
Housing	Housing Habitability	95%	↓	99%
	Homeownership	60%	↑	60%
Climate and Environment	Drought Risk	16	—	52
	Air pollution: PM2.5 concentration	11	—	15

** Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Income in CT 38.03 has increased substantially since the 2022 CHNA and is higher than SJC.

Educational attainment plays a critical role in long-term economic security. Compared to SJC, CT 38.03 has a much smaller percentage of adults with education beyond high school.

SNAP enrollment (food assistance) in CT 38.03 has more than doubled since the 2022 CHNA and is substantially higher than SJC, indicating that residents require support to meet basic needs.

Birth and Death Statistics

In comparison to the County overall, this neighborhood has lower birth rates across all racial/ethnic groups, more teen births, pre-term births, and babies born at low birth weights, and fewer pregnant persons receiving prenatal care early in their pregnancy.

Table 3: Birth Outcomes (CT 38.03 vs SJC)

Measure Name	CT 38.03	Change Since 2022 CHNA	SJC
Pre-term births	11%	↓	9%

Low birth weight	9%	↑↑	8%
Prenatal care in 1st trimester	74%	↑	79%
Teen births (mothers ages 15- 19 yrs)	6%	↑	4%
Birth Rate			
Total	9	↓	13
Asian	7	↓↓	13
Black/African American	7	↑↑	12
Hispanic	12	↓	15
White	5	↓	8

Refer to technical notes for data sources.

In this neighborhood, the Black/African American population is dying at the youngest age when compared to other racial/ethnic groups, followed by the Hispanic population. The age-adjusted death rate is lower in this CT compared to the County. This neighborhood's rates of death due to heart disease, cancer, COVID-19, and stroke are all lower than the County's rates, but rates of death from diabetes in CT 38.03 are higher than in SJC.

Table 4: Death Statistics (CT 38.03 vs SJC)

Measure Name	CT 38.03	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	80	—	77
Average Age of Death (yrs)			
Total	71	↑	71
Asian	79	↓	72
Black/African American	63	↓	64
Hispanic	66	↑	65
White	74	↑	75
Age-Adjusted Death Rate - Total	636	↓	832
Top 5 Causes of Death			
Heart disease deaths	141	↑	148
Cancer deaths	103	↑	144
COVID-19 deaths	49	↑	61
Diabetes deaths	44	↑	30
Stroke deaths	40	↑	50

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 40.01

San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 40.01 in the unincorporated community of Thornton is bounded by the following streets: Mokelumne River on the west and north, White Slough on the south, and I-5 on the east. This Priority Neighborhood is home to 2,249 people.

Demographics

The majority of this neighborhood's residents are Hispanic, followed by White, and between the ages of 25 and 64 years old. The Asian and Black/African American populations represent a smaller percentage of the total population in CT 40.01 as compared to the County (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last community health needs assessment (CHNA) was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 40.01 vs SJC)

		CT 40.01	Change Since 2022 CHNA	SJC
Total Population		2,249	↑	779,445
Race/Ethnicity	Asian	4%	—	17%
	Black/African American	2%	↑↑↑↑	7%
	Hispanic	52%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%

	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	40%	↓	29%
	Multiple Races	2%	↑↑↑	4%
Gender	Female	46%	↓	50%
	Male	55%	↑	50%
Age Group	0- 5 yrs	7%	↑	8%
	6- 17 yrs	16%	↓	19%
	18- 24 yrs	9%	↑	10%
	25- 44 yrs	26%	—	27%
	45- 64 yrs	27%	↑	23%
	≥65 yrs	15%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood fares worse than the County across economics, social support, and education; disparities are notable for income and at least 10 percentage points worse than the County for the percent of insured adults, limited English proficiency, and adults with no high school diploma. In contrast, CT 40.01 performs better than the County on access to grocery stores (10 percentage points or more) and on drought risk. Compared to the 2022 CHNA, there have been improvements in income, percent living in poverty, employment, adults with a bachelor's or higher education, and homeownership. However, the percent of insured adults, two parent households, limited English proficiency, preschool enrollment, adults with no high school diploma, SNAP enrollment, automobile access, and active commuting conditions have worsened.

Table 2: Root Causes of Health (CT 40.01 vs SJC)

Health Topic	Measure Name	CT 40.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	80%	↓	91%
	Uninsured children (ages <19 yrs)	1%	—	3%
Economic	**Income**	$49,609	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	22%	↓	13%
	Employed (ages 20- 64 yrs)	69%	↑	70%
Social Support	Two Parent Households	73%	↓	77%
	Limited English Proficiency	52%	↑↑↑	41%
Education	Preschool Enrollment	44%	↓	38%

While income in CT 40.01 has increased since the 2022 CHNA, it is only 60% of the SJC average.

	Adults (ages 25+ yrs) with no high school diploma	32%	↑	20%
	Bachelor's Education or Higher	12%	↑↑↑	20%
Food Security	**Low Access to Grocery Stores**	3%	—	28%
	SNAP Enrollment	20%	↑↑↑	15%
Transportation	Automobile Access	97%	↓	95%
	Active Commuting	3%	↓↓	3%
Built Environment	Retail Density	0%	—	<1%
	Urban Tree Canopy	—	—	—
Housing	Housing Habitability	99%	—	99%
	Homeownership	57%	↑	60%
Climate and Environment	Drought Risk	41	—	52
	Air pollution: PM2.5 concentration	10	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Educational attainment is linked to economic security. In CT 40.01 the % of adults with education beyond high school is substantially lower than SJC overall.

Access to grocery stores impacts ability to buy healthy foods. Residents of CT 40.01 have much better access to grocery stores than SJC overall.

Birth and Death Statistics

In comparison with the County overall, this neighborhood has a higher birth rate among Black/African American residents, while all other racial/ethnic groups have lower birth rates. While there are smaller percentages of pre-term births and babies born at a low birth weight than in the County, the rate of low birth weight has greatly increased since the 2022 CHNA, as has births from teen mothers.

Table 3: Birth Outcomes (CT 40.01 vs SJC)

Measure Name	CT 40.01	Change Since 2022 CHNA	SJC
Pre-term births	5%	↓↓	9%
Low birth weight	7%	↑↑↑↑	8%
Prenatal care in 1st trimester	68%	↓	79%
Teen births (mothers ages 15- 19 yrs)	9%	↑↑↑↑	4%
Birth Rate			
Total	9	↓	13
Asian	6	—	13
Black/African American	23	↓	12
Hispanic	11	↑	15
White	6	↓	8

Refer to technical notes for data sources.

In this neighborhood, the age-adjusted death rate is higher than the County's overall rate for all groups combined, and Black/African American residents are dying at a younger age when compared to other racial/ethnic groups, followed by Hispanic residents. For the CT 40.01 top five causes of death, the rates of death due to heart disease, cancer, unintentional injuries, despair, and COVID-19 are higher than in SJC. Compared to the 2022 CHNA, the rate of death due to cancer, unintentional injuries, despair, and COVID-19 has increased while the rate of death due to heart disease has decreased.

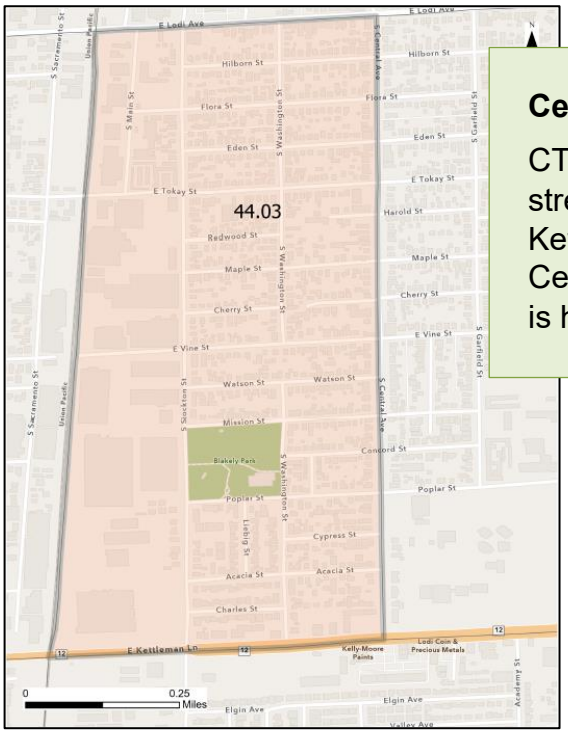
Table 4: Death Statistics (CT 40.01 vs SJC)

Measure Name	CT 40.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	78	—	77
Total	70	↓	71
Asian	85	—	72
Black/African American	45	—	64
Hispanic	59	↑	65
White	72	↓	75
Age-Adjusted Death Rate - Total	882	↑	832
Top 5 Causes of Death			
Heart disease deaths	177	↓↓	148
Cancer deaths	156	↑	144
Unintentional injury deaths	89	↑↑	55
Deaths of despair	55	↑↑	44
COVID-19 deaths	53	↑↑↑↑	61

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 44.03



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 44.03 in Lodi is bounded by the following streets: Sacramento/Stockton on the west, Kettleman on the south, Lodi on the north, and Central on the east. This Priority Neighborhood is home to 3,800 people.

Demographics

The majority of this neighborhood's residents are Hispanic, and about one-third of the population falls between the ages of 25 and 44. Since the 2022 community health needs assessment (CHNA), CT 44.03 experienced increases in the Asian and Multiple Race populations, as well as the percent of the population ages 18-24 and 45-64 (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 44.03 vs SJC)

		CT 44.03	Change Since 2022 CHNA	SJC
Total Population		3,800	—	779,445
Race/Ethnicity	Asian	33%	↑↑	17%
	Black/African American	0%	—	7%
	Hispanic	51%	↓	43%

	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	11%	—	29%
	Multiple Races	5%	↑↑↑↑↑	4%
Gender	Female	50%	↑	50%
	Male	50%	↓	50%
Age Group	0- 5 yrs	13%	↑	8%
	6- 17 yrs	22%	↓	19%
	18- 24 yrs	10%	↑↑	10%
	25- 44 yrs	29%	↓	27%
	45- 64 yrs	20%	↑↑	23%
	≥65 yrs	7%	↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

When looking at the root causes of health, CT 44.03 performs worse than the County on economics and education. Income in this CT is substantially lower than the SJC average and disparities (at least 10 percentage points worse than the County) are present for the percent of insured adults, percent living in poverty, employment, limited English proficiency, preschool enrollment, adult educational attainment, automobile access, and homeownership. This neighborhood performs better (10 percentage points or more) than the County on access to grocery stores. Since the 2022 CHNA, this neighborhood has improved on uninsured children, preschool enrollment, adults with a bachelor's education or higher, and SNAP enrollment. However, the percent of insured adults, income, percent living in poverty, employment, limited English proficiency, adults without a high school diploma, automobile access, active commuting, and homeownership have worsened since the 2022 CHNA.

Table 2: Root Causes of Health (CT 44.03 vs SJC)

Health Topic	Measure Name	CT 44.03	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	73%	↓	91%
	Uninsured children (ages <19 yrs)	3%	↓↓	3%
Economic	Income	$28,992	↓↓	$82,837
	Living in poverty (<100% Federal Poverty Level)	44%	↑↑	13%

Poverty directly impacts health and well-being. Poverty increased since the 2022 CHNA and is over three times higher than the SJC poverty rate.

	Employed (ages 20- 64 yrs)	56%	↓	70%
Social Support	Two Parent Households	83%	↓	77%
	Limited English Proficiency	54%	↑↑	41%
Education	Preschool Enrollment	19%	↑↑↑↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	49%	↑	20%
	Bachelor's Education or Higher	8%	↑↑↑↑↑	20%
Food Security	Low Access to Grocery Stores	11%	—	28%
	SNAP Enrollment	22%	↓	15%
Transportation	Automobile Access	81%	↓	95%
	Active Commuting	4%	↓↓	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	9%	—	—
Housing	Housing Habitability	100%	—	99%
	Homeownership	30%	↓	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	11	—	15

The % of adults without a high school diploma in CT 44.03 is more than double SJC overall.

Homeownership is related to housing stability. The CT 44.03 homeownership rate is 50% lower than the SJC rate and has decreased since the 2022 CHNA.

** Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County overall, this neighborhood performs worse on preterm births, early prenatal care, and teen births. This neighborhood's birth rates (across most racial/ethnic groups) are higher than the County. Since the 2022 CHNA, this neighborhood has experienced a substantial increase in pre-term births and babies born at low birth weight.

Table 3: Birth Outcomes (CT 44.03 vs SJC)

Measure Name	CT 44.03	Change Since 2022 CHNA	SJC
Pre-term births	11%	↑↑↑↑	9%
Low birth weight	8%	↑↑↑↑	8%
Prenatal care in 1st trimester	69%	↓	79%
Teen births (mothers ages 15- 19 yrs)	7%	↓	4%
Birth Rate			

Total	19	↓	13
Asian	14	↓↓	13
Black/African American	—	—	12
Hispanic	25	↑	15
White	12	↓	8

Refer to technical notes for data sources.

In this neighborhood, Asian and Hispanic residents are dying at a younger age than other racial/ethnic groups. Across all racial/ethnic groups the average age of death is lower than County averages. Compared to the 2022 CHNA, the average age of death among Asian and White residents has increased, while the average age among the Hispanic population has decreased. For the top five causes of death, the rates of death due to heart disease, COVID-19, unintentional injuries, and despair are higher in this neighborhood than the County; in contrast, deaths due to cancer are slightly lower in CT 44.03. The rates of death due to unintentional injuries and despair have increased substantially since the 2022 CHNA, while the rate of death due to COVID-19 has decreased.

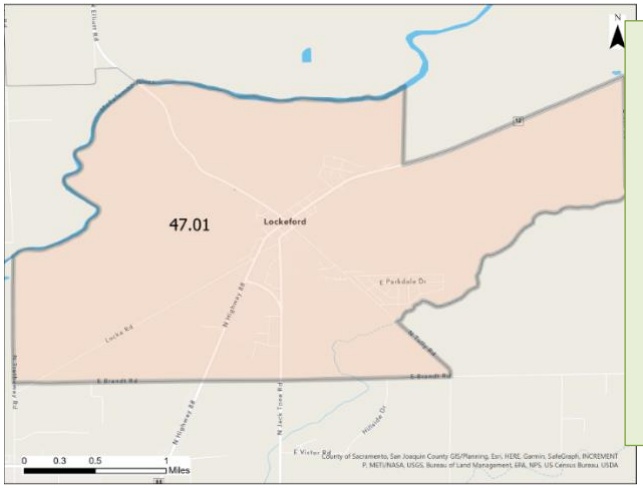
Table 4: Death Statistics (CT 44.03 vs SJC)

Measure Name	CT 44.03	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	78	—	77
Average Age of Death (yrs)			
Total	64	↓	71
Asian	58	↑	72
Black/African American	—	—	64
Hispanic	58	↓	65
White	72	↑	75
Age-Adjusted Death Rate - Total	983	↑	832
Top 5 Causes of Death			
Heart disease deaths	162	↑	148
Cancer deaths	141	↑	144
COVID-19 deaths	111	↓↓↓	61
Unintentional injury deaths	69	↑↑↑	55
Deaths of Despair	65	↑↑↑	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 47.01



Census tract (CT) description:

CT 47.01 in the unincorporated community of Lockeford is bounded by the following streets: Tretheway on the west, Brandt on the south, Mokelumne River on the north, and Disch on the east. This Priority Neighborhood is home to 3,426 people.

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Demographics

The majority of this neighborhood's residents are White and above the age of 25 years old. There is a slightly higher percentage of males than females when compared to SJC overall. Since 2022, CT 47.01 experienced an increase in the Asian and Multiple Race populations. The percent of the population age 65 years and older is increasing (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last community health needs assessment (CHNA) was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 47.01 vs SJC)

		CT 47.01	Change Since 2022 CHNA	SJC
Total Population		3,426	↑	779,445
Race/Ethnicity	Asian	1%	↑↑↑↑↑	17%
	Black/African American	<1%	—	7%

	Hispanic	36%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	58%	↓	29%
	Multiple Races	4%	↑↑↑↑	4%
Gender	Female	44%	↑	50%
	Male	56%	↓	50%
Age Group	0- 5 yrs	9%	↓	8%
	6- 17 yrs	16%	↓	19%
	18- 24 yrs	7%	↓	10%
	25- 44 yrs	23%	↑	27%
	45- 64 yrs	22%	↑	23%
	≥65 yrs	24%	↑↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood performs similar to the County across health topics. CT 47.01 measures at least 10 percentage points worse than the County on two parent households, preschool enrollment, and access to grocery stores. In contrast, this neighborhood has a higher average income than SJC overall and performs better (10 percentage points or more) than the County on measures of homeownership and drought risk. Since the 2022 CHNA, CT 47.01 has improved on the percent of uninsured children, income, percent living in poverty, employment, two parent households, adult educational attainment, SNAP enrollment, and homeownership. However, the percent of insured adults, limited English proficiency, preschool enrollment, automobile access, and housing habitability have worsened.

Table 2: Root Causes of Health (CT 47.01 vs SJC)

Health Topic	Measure Name	CT 47.01	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	83%	↓	91%
	Uninsured children (ages <19 yrs)	<1%	↓↓↓↓	3%
Economic	Income	$105,870	↑↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	10%	↓↓↓	13%
	Employed (ages 20- 64 yrs)	73%	↑	70%
Social Support	**Two Parent Households**	60%	↑	77%
	Limited English Proficiency	34%	↑↑↑↑↑	41%

CT 47.01 has a smaller percentage of households with 2 parents than the SJC average.

Education	Preschool Enrollment	7%	↓	38%
	Adults (ages 25+ yrs) with no high school diploma	12%	↓↓	20%
	Bachelor's Education or Higher	28%	↑↑	20%
Food Security	**Low Access to Grocery Stores**	47%	—	28%
	SNAP Enrollment	6%	↓	15%
Transportation	Automobile Access	98%	↓	95%
	Active Commuting	2%	—	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	—	—	—
Housing	Housing Habitability	99%	↓	99%
	Homeownership	86%	↑	60%
Climate and Environment	Drought Risk	11	—	52
	Air pollution: PM2.5 concentration	10	—	15

Access to grocery stores is linked to ability to purchase healthy foods. CT 47.01 residents have less access to grocery stores than SJC overall.

Homeownership is an element of economic and housing stability. Residents in CT 47.01 are more likely to own their homes than in SJC overall.

Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.
Refer to technical notes for data sources.

Birth and Death Statistics

When compared with the County, CT 47.01 has lower birth rates across all racial/ethnic groups. There are fewer pre-term births, babies born at low birth weights, and teen births in this neighborhood as compared to the County overall. Compared to the 2022 CHNA, fewer pregnant persons are receiving early prenatal care and there is an increase in pre-term births. However, there is a decrease in babies born at low birth weight and a decrease in teen births.

Table 3: Birth Outcomes (CT 47.01 vs SJC)

	CT 47.01	Change Since 2022 CHNA	SJC
Pre-term births	7%	↑	9%
Low birth weight	5%	↓	8%
Prenatal care in 1st trimester	78%	↓	79%
Teen births (mothers ages 15- 19 yrs)	3%	↓↓	4%
Birth Rate			
Total	7	↓	13

Asian	9	—	13
Black/African American	—	—	12
Hispanic	8	↓↓	15
White	6	↓	8

Refer to technical notes for data sources.

In this neighborhood, the age adjusted death rate is lower for all groups combined than the County overall rate. The Asian population is dying at the youngest age on average when compared with other racial/ethnic groups. Rates for CT 47.01's five top causes of death are lower than the County's. Since the 2022 CHNA, rates of death due to heart disease and lung disease have increased, while the rates of death due to cancer, unintentional injuries, and stroke have decreased.

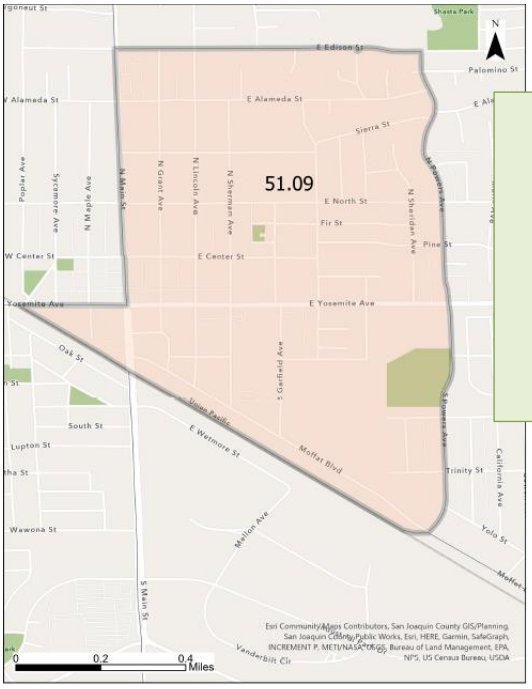
Table 4: Death Statistics (CT 47.01 vs SJC)

Measure Name	CT 47.01	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	79	—	77
Average Age of Death (yrs)			
Total	73	↓	71
Asian	59	—	72
Black/African American	—	—	64
Hispanic	66	↓	65
White	75	↓	75
Age-Adjusted Death Rate - Total	697	↓↓	832
Top 5 Causes of Death			
Heart disease deaths	142	↑	148
Cancer deaths	138	↓	144
Unintentional injury deaths	37	↓	55
Lung disease deaths	36	↑	37
Stroke deaths	34	↓	50

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 51.09



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 51.09 in Manteca is bounded by the following streets: Main on the west, Moffat on the south, Edison on the north, and Powers on the east. This Priority Neighborhood is home to 3,493 people.

Demographics

The neighborhood's residents are predominantly Hispanic and White, and almost half are between the ages of 25 and 64. Since the 2022 community health needs assessment (CHNA), demographic changes in CT 51.09 include a decrease in the Asian population, increase in the White population and a decrease in the percent of the population ages 0-5 (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 51.09 vs SJC)

		CT 51.09	Change Since 2022 CHNA	SJC
Total Population		3,493	↓	779,445
Race/Ethnicity	Asian	1%	↓↓↓	17%
	Black/African American	2%	↑	7%

	Hispanic	46%	↓	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	1%	—	<1%
	White	46%	↑↑	29%
	Multiple Races	4%	↓	4%
Gender	Female	51%	↑	50%
	Male	49%	↓	50%
Age Group	0- 5 yrs	6%	↓↓	8%
	6- 17 yrs	17%	↑	19%
	18- 24 yrs	13%	↑	10%
	25- 44 yrs	26%	↓	27%
	45- 64 yrs	23%	↑	23%
	≥65 yrs	16%	↑	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

This neighborhood fares worse than the County overall on access to care, economics, social support, and transportation. Income in this neighborhood is substantially lower than the County average income and disparities (at least 10 percentage points worse than the County) are present for limited English proficiency and homeownership. In contrast, this neighborhood performs better (10 percentage points or more) than the County on preschool enrollment and SNAP enrollment. Since the 2022 CHNA, this neighborhood has improved on income, employment, preschool enrollment, adult educational attainment, SNAP enrollment, automobile access, and homeownership. Adult and child insurance coverage, percent living in poverty, two parent households, limited English proficiency, and active commuting are worse compared to the 2022 CHNA.

Table 2: Root Causes of Health (CT 51.09 vs SJC)

Health Topic	Measure Name	CT 51.09	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	88%	↓	91%
	Uninsured children (ages <19 yrs)	10%	↑	3%
Economic	Income	$53,542	↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	21%	↑	13%
	Employed (ages 20- 64 yrs)	68%	↑	70%

Poverty impacts health and well-being. In CT 51.09, the percentage of those living in poverty increased since the 2022 CHNA and is higher than SJC.

Social Support	Two Parent Households	75%	↓	77%
	Limited English Proficiency	52%	↑↑↑↑↑	41%
Education	Preschool Enrollment	63%	↑↑	38%
	Adults (ages 25+ yrs) with no high school diploma	13%	↓↓	20%
	Bachelor's Education or Higher	16%	↑↑↑↑↑	20%
Food Security	Low Access to Grocery Stores	—	—	28%
	SNAP Enrollment	5%	↓↓↓	15%
Transportation	Automobile Access	93%	↑	95%
	Active Commuting	2%	↓↓↓	3%
Built Environment	Retail Density	1%	—	<1%
	Urban Tree Canopy	8%	—	—
Housing	Housing Habitability	100%	—	99%
	Homeownership	46%	↑↑	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	11	—	15

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Educational attainment plays a role in economic security. In CT 51.09, the percentage of adults with education beyond high school has more than doubled since the 2022 CHNA.

Homeownership is linked with economic and housing stability. Homeownership in CT 51.09 has increased since the 2022 CHNA but remains lower than SJC overall.

Birth and Death Statistics

When compared with the County overall, CT 51.09 performs better when it comes to pre-term births, teen births, low birth weight babies, and receiving prenatal care in the first trimester. Compared to the 2022 CHNA, there are more babies born at a low birth weight. This neighborhood has a higher total birth rate among all groups combined than the County overall; birth rates among Asian and Hispanic residents have increased since the 2022 CHNA, while the White birth rate has decreased.

Table 3: Birth Outcomes (CT 51.09 vs SJC)

Measure Name	CT 51.09	Change Since 2022 CHNA	SJC
Pre-term births	8%	↓	9%
Low birth weight	7%	↑↑↑	8%
Prenatal care in 1st trimester	81%	↑	79%
Teen births (mothers ages 15- 19 yrs)	3%	↑	4%
Birth Rate			
Total	14	—	13

Asian	46	↑↑↑↑↑	13
Black/African American	30	↓	12
Hispanic	21	↑↑	15
White	6	↓↓	8

Refer to technical notes for data sources.

In this neighborhood, Asian residents are dying at the youngest age on average compared to all other racial/ethnic groups. The age-adjusted death rate among all groups combined is higher than the County rate. This neighborhood's rates of death due to heart disease, cancer, COVID-19, lung disease, and despair are all higher than the County rates. In comparison to the 2022 CHNA, the average age of death among the Asian, Hispanic, and White populations has increased, while the average age of death has decreased among the Black/African American population. Deaths due to lung disease and despair have increased since the 2022 CHNA, while COVID-19 deaths have decreased.

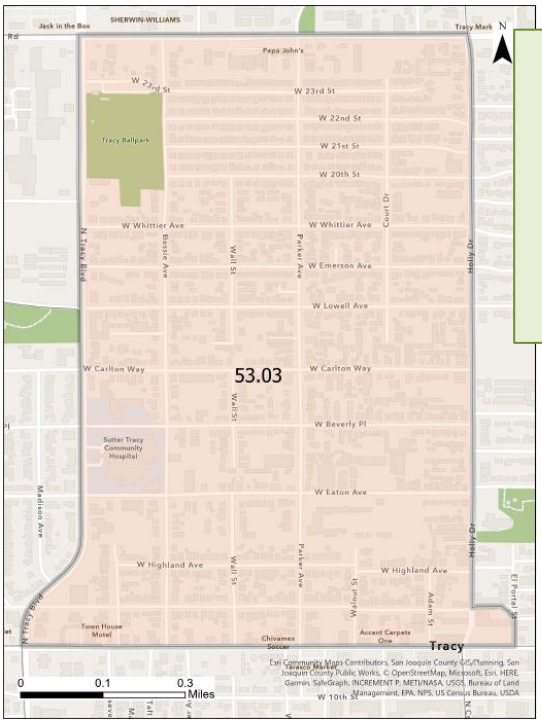
Table 4: Death Statistics (CT 51.09 vs SJC)

Measure Name	CT 51.09	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	72	—	77
Average Age of Death (yrs)			
Total	72	↑	71
Asian	63	↑	72
Black/African American	67	↓	64
Hispanic	65	↑	65
White	76	↑	75
Age-Adjusted Death Rate - Total	1,223	—	832
Top 5 Causes of Death			
Heart disease deaths	257	↑	148
Cancer deaths	146	↓	144
COVID-19 deaths	86	↓↓	61
Lung disease deaths	85	↑↑	37
Deaths of despair	71	↑↑	44

Refer to technical notes for data sources.

PRIORITY NEIGHBORHOOD PROFILE

Census Tract 53.03



San Joaquin County Public Health Services, Epidemiology. 06/25/2024

Census tract (CT) description:

CT 53.03 in Tracy is bounded by the following streets: Tracy on the west, 11th on the south, Grant Line on the north, and Holly on the east. This Priority Neighborhood is home to 6,454 people.

Demographics

Just over two-thirds of the neighborhood's residents are Hispanic, and just over one third are between the ages of 25 and 44. Since the 2022 community health needs assessment (CHNA), demographic changes in CT 53.03 include a decrease in the White population and increases in the Asian, Hispanic, and Multiple Races populations. CT 53.03 has a growing young population, with all age groups 44 years and younger experiencing increases since the 2022 CHNA, while ages 45 years and older decreased during this time (Table 1).

How to read the tables that follow: This profile presents data for the CT and San Joaquin County (SJC) and explores how this CT has changed since the last CHNA was conducted in 2022. The middle column in the tables below illustrates change using up arrows ↑ to indicate an increase, down arrows ↓ to indicate a decrease, and a dash — to indicate no change or inability to calculate percent change (due to missing data or zero for the 2022 CHNA value). One arrow equals a 1- 25% change, two arrows equal a 26- 50% change, three arrows equal a 51- 75% change, four arrows equal a 76- 100% change, and five arrows equal a >100% change.

Table 1: Population (CT 53.03 vs SJC)

		CT 53.03	Change Since 2022 CHNA	SJC
Total Population		6,454	↑↑	779,445
Race/Ethnicity	Asian	6%	↑↑	17%

	Black/African American	4%	↓	7%
	Hispanic	68%	↑	43%
	American Indian/Alaska Native	<1%	—	<1%
	Pacific Islander/Native Hawaiian	<1%	—	<1%
	White	18%	↓↓	29%
	Multiple Races	3%	↑↑↑↑	4%
Gender	Female	47%	—	50%
	Male	53%	—	50%
Age Group	0- 5 yrs	16%	↑↑	8%
	6- 17 yrs	21%	↑	19%
	18- 24 yrs	9%	↑	10%
	25- 44 yrs	34%	↑	27%
	45- 64 yrs	14%	↓	23%
	≥65 yrs	7%	↓↓	13%

Refer to technical notes for data sources.

Social Conditions Linked to Health

Compared to the County overall, CT 53.03 fares worse on access to care, economics, education, and housing. Disparities (10 or more percentage points worse) compared to the County are present for the percent living in poverty and homeownership. This neighborhood performs better (10 percentage points or more) than the County on grocery store access. Since the 2022 CHNA, this neighborhood has improved on insurance coverage for adults and children, income, employment, SNAP enrollment, and active commuting, while the percent living in poverty, two parent households, limited English proficiency, preschool enrollment, adult educational attainment, housing habitability, and homeownership have worsened.

Table 2: Root Causes of Health (CT 53.03 vs SJC)

Health Topic	Measure Name	CT 53.03	Change Since 2022 CHNA*	SJC
Access to care	Insured (ages 19-64 yrs)	89%	↑	91%
	Uninsured children (ages <19 yrs)	7%	↓↓	3%
Economic	Income	$81,889	↑↑	$82,837
	Living in poverty (<100% Federal Poverty Level)	25%	↑↑	13%

Poverty directly impacts health and well-being. In CT 53.03, the % living in poverty has increased since the 2022 CHNA and is almost double the SJC %.

	Employed (ages 20- 64 yrs)	78%	↑	70%
Social Support	Two Parent Households	73%	↓	77%
	Limited English Proficiency	32%	↑↑	41%
Education	**Preschool Enrollment**	37%	↓↓	38%
	Adults (ages 25+ yrs) with no high school diploma	24%	↑	20%
	Bachelor's Education or Higher	11%	↓	20%
Food Security	Low Access to Grocery Stores	<1%	—	28%
	SNAP Enrollment	12%	↓	15%
Transportation	Automobile Access	96%	—	95%
	Active Commuting	9%	↑↑↑↑↑	3%
Built Environment	Retail Density	<1%	—	<1%
	Urban Tree Canopy	20%	—	—
Housing	Housing Habitability	97%	↓	99%
	Homeownership	29%	↓	60%
Climate and Environment	Drought Risk	—	—	52
	Air pollution: PM2.5 concentration	9	—	15

Preschool is linked to academic achievement. CT 53.03 had a decrease in preschool enrollment since the 2022 CHNA.

Active commuting, which supports physical/mental health and contributes to environmental sustainability, has substantially increased in CT 53.03 since the 2022

**Arrow direction does not indicate negative/positive change; orange (↓↑) indicates negative change, green (↓↑) indicates improvement.*
Refer to technical notes for data sources.

Birth and Death Statistics

CT 53.03 fares better than the County on pre-term births and babies born at a low birth weight. In contrast, this neighborhood has lower performance on early prenatal care and teen births. In comparison to the 2022 CHNA, performance has worsened for babies born at a low birth weight and teen births. The birth rate among Asian residents has increased since the 2022 CHNA, while rates for all other racial/ethnic groups have decreased.

Table 3: Birth Outcomes (CT 53.03 vs SJC)

Measure Name	CT 53.03	Change Since 2022 CHNA	SJC
Pre-term births	8%	—	9%
Low birth weight	7%	↑↑↑	8%
Prenatal care in 1st trimester	78%	↑	79%
Teen births (mothers ages 15- 19 yrs)	5%	↑↑	4%
Birth Rate			
Total	10	↓↓	13
Asian	14	↑	13

Black/African American	9	↓	12
Hispanic	10	↓↓	15
White	9	↓↓	8

Refer to technical notes for data sources.

This neighborhood, compared to the County overall, has a higher age adjusted death rate. Hispanic residents have the lowest average age of death in this neighborhood compared to all other racial/ethnic groups. Since the 2022 CHNA, Black/African American residents of CT 53.03 are living longer while the average age of death decreased for all other population groups. For the top five causes of death, CT 53.03 has higher rates of death for heart disease, cancer, COVID-19, stroke, and Alzheimer's compared to the County's rates. Compared to the 2022 CHNA, the rate of death due to COVID-19 has decreased and the rates of death due to heart disease, stroke, and Alzheimer's have increased.

Table 4: Death Statistics (CT 53.03 vs SJC)

Measure Name	CT 53.03	Change Since 2022 CHNA	SJC
Life expectancy (yrs)	76	—	77
Average Age of Death (yrs)			
Total	70	↓	71
Asian	84	↓	72
Black/African American	71	↑	64
Hispanic	63	↓	65
White	75	↓	75
Age-Adjusted Death Rate - Total	889	↓	832
Top 5 Causes of Death			
Heart disease deaths	172	↑↑	148
Cancer deaths	145	↑	144
COVID-19 deaths	78	↓↓↓	61
Stroke deaths	73	↑↑	50
Alzheimer's deaths	52	↑↑	35

Refer to technical notes for data sources.

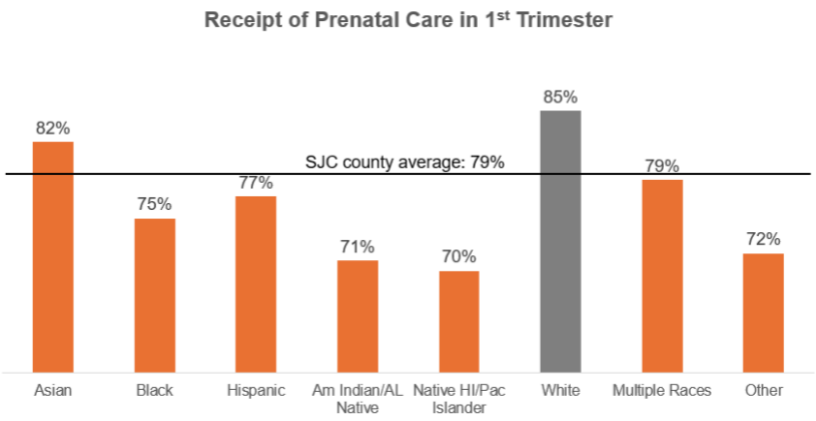
B. Health Need Profiles

Access to Care

Rationale: Why this is a critical health need

Access to comprehensive, quality healthcare is essential for achieving and maintaining health and for increasing quality of life. Components of access to and delivery of care include: insurance coverage; adequate numbers of primary/specialty care providers; health care timeliness, quality, and transparency; and culturally aligned healthcare. Limited access to healthcare and compromised healthcare delivery negatively affect health and quality of life.

Access to care	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Infant deaths (per 1000 live births)	Yes	No	↓
Uninsured children (ages <19 yrs)	No	Yes	↑
Insured (ages 19-64 yrs)	No	Yes	–
Medi-Cal enrollment	No	N/A	↓
Low birth weight	Yes	Yes	↑
Pre-term births	Yes	Yes	↓
Prenatal care in 1st trimester	Yes	Yes	↓
Dentists per 100,000 population	Yes	N/A	↑
Primary care physicians per 100,000 population	Yes	N/A	↓



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Key findings and disparities across San Joaquin County (based on health data)

- SJC residents have access to significantly fewer health care providers than the CA average. SJC has 29% fewer primary care physicians (58 per 100,000 population) and 35% fewer dentists (59 per 100,000 population) than the state benchmarks (82 and 91 per 100,000, respectively).
- Newborn infants in SJC experience significantly worse outcomes compared to CA averages: infant deaths per 1,000 live births in SJC (5) are 20% higher than CA (4) and low birth weight births (8%) are significantly higher than CA (7%).
- The percentage of pregnant persons receiving prenatal care in the first trimester in SJC (79%) is significantly lower than the CA benchmark (86%); pregnant persons of all ethnicities/races have a significantly lower likelihood of receiving prenatal care than White pregnant persons in SJC.

- SJC has a lower percent of uninsured children and adults than CA, but disparities are present; American Indian/Alaskan Native children (4%) are more likely to be uninsured than White children (3%), and significantly fewer Hispanic (90%), American Indian/Alaskan Native (91%), and Multiracial (93%) adults are insured in SJC than White adults (97%).

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- Prenatal care in the first trimester of pregnancy is lower in 13 of 14 Priority Neighborhoods as compared to SJC overall.
- 12 of 14 Priority Neighborhoods have higher rates of teen births than SJC.
- Since the 2022 CHNA, CT 40.01 experienced increases in low birth weight rates and teen births and a decrease in the rate of prenatal care during the first trimester.

What community stakeholders say about access to care (based on key informant interviews and focus groups)

Overall

- 48% (19 out of 40) of focus groups and 4 of 10 key informants identified access to care as a top priority health need in SJC.
- Focus group participants described ongoing healthcare and dental provider shortages resulting in frustration about long waits and substantial travel to appointments.
- Key informants noted that many specialty healthcare services are unavailable locally, difficult to access or have long wait times.
- Limited, daytime clinic hours present a healthcare barrier to many community members, particularly for agricultural workers, those without paid time off, or those with long commutes, according to key informants and focus group participants.

> "There's a very big divide [in the ability to access healthcare]...whether it's by provider, whether it's dental services, whether it's emergency services...or products and resources for health care." – *Community Based Organization Leader*

- Telehealth addresses some provider gaps and transportation challenges, but many focus group participants and key informants expressed dissatisfaction with virtual healthcare, especially for residents lacking Internet connectivity or with limited literacy and/or technology skills.
- Focus group participants and key informants reported pervasive distrust of the healthcare system/providers and negative beliefs within communities around accessing healthcare.

Disparities

- Focus group participants noted the lack of healthcare providers who speak residents' languages and understand, represent, or respect their cultures, echoing key informants' reports that healthcare organizations need to employ diverse, representative providers.
- Health insurance applications were viewed by key informants and focus group participants as burdensome and complicated, especially for older adults, non-English speakers, and immigrants.

> "We need health professionals who are as diverse as the population they serve." – *Focus group participant*

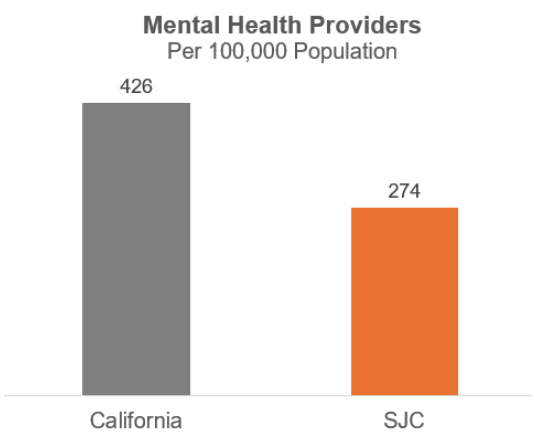
- Several key informants and focus group participants cited the success of pandemic era pop-up/mobile vaccination and testing clinics, which created access points for other healthcare services in underserved communities.

Mental health including substance use

Rationale: Why this is a critical health need

Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school, and to participate fully in family and community activities. Deaths of despair — due to suicide, drug overdose, and alcoholism — are on the rise. Communities are experiencing a critical lack of capacity to meet the increased demand for mental health and substance use treatment services.

Mental health	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Mental health providers per 100,000 pop	Yes	N/A	↑
Deaths of despair per 100,000 pop	Yes	Yes	↑↑
Suicide deaths	No	Yes	↑
Poor mental health (days per month)	No	N/A	↑
Substance use			
Current smokers	Yes	N/A	↓
Alcohol-impaired driving deaths	Yes	N/A	↑
Opioid-related overdose deaths per 100,000 pop	No	Yes	↑↑
Excessive drinking	No	NA	↓



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Key findings and disparities across San Joaquin County (based on health data)

- SJC residents have access to significantly fewer mental health care providers; SJC has 36% fewer mental health practitioners than the state.
  - Since 2019, SJC has only added half as many mental health providers per 100,000 residents as CA: 36 versus 73 providers per 100,000 population.
- Deaths of despair (due to suicide, alcohol related disease, and drug overdoses) in SJC have increased 48% over the past three years and are almost 13% higher in SJC (64 per 100,000 population) than in CA overall (56 per 100,000 population).
- Black/African American SJC residents experience significantly more opioid overdose deaths (39 per 100,000 population) than White residents (17 per 100,000 population).
- 13% of SJC adults are current smokers, compared to only 9% of Californians. Both of these rates have decreased since the 2022 CHNA.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- Despair is among the top 5 causes of death in 8 of 14 Priority Neighborhoods.
- CT 27.01 and CT 44.03 have experienced substantial increases in deaths of despair since the 2022 CHNA.

What community stakeholders say about mental health and substance use (based on key informant interviews and focus groups)

Overall

- 65% (26 of 40) focus groups and 4/10 key informants identified mental health as a top priority in SJC.
- 53% (21 of 40) focus groups and 5/10 key informants identified substance use as a top priority in SJC.
- Key informants stated that pandemic impacts on mental health are continuing, especially affecting children, young adults, older adults, and health care workers.
- Many focus group participants described mental health as the number one health issue and need within their communities.
- Both key informants and focus group participants highlighted concern for children's mental health and the associated increase in drug, alcohol, and vaping use among children and teens.
- Key informants and many focus group participants pointed out the intersection of mental health needs, substance use, and homelessness and the damage this trifecta has inflicted on the health, safety, and morale of communities.

> "There's just not enough [mental health] support to meet the needs and the type of support is inconsistent and has challenges, being able to be consistent. The type of service base that has been built does not meet the need...we have an old system that is not meeting new needs."
> – *Community Based Organization Leader*

- Available mental health treatment is often not flexible enough to be of use to residents lacking housing stability or consistent sobriety, according to key informants; focus group participants reported that some organizations providing substance use/addiction treatment are inadequately funded/staffed or challenged by politics/red tape.
- Focus group participants expressed frustration with ubiquitous smoke shops, liquor stores, and dispensaries in their communities that normalize/promote substance use, make substances readily available, and contribute to drug related activities in parks, on sidewalks, and near public spaces.

Disparities

- Focus group participants emphasized the importance of receiving mental health services from diverse providers, who reflect the races, cultures, and languages of SJC residents.
- Timely services for mental health crises are limited to nonexistent in some communities, according to focus group participants; key informants specified that farm and migrant workers in rural areas have difficulty accessing mental health preventive services and treatment.

> "Mental health is something that affects the south side [of Stockton] more." – *Public health official*

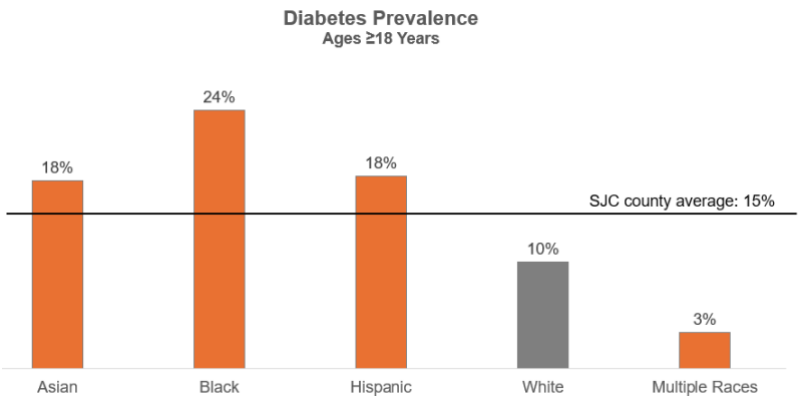
- Key informants observed that SJC is deficient in substance use treatment services tailored to the needs of underserved groups, noting the lack of residential treatment for youth and services for LGBTQIA+ individuals based on harm reduction principles.
- Substance use was perceived by focus group participants as a coping mechanism/self-medication for marginalized, underserved residents.

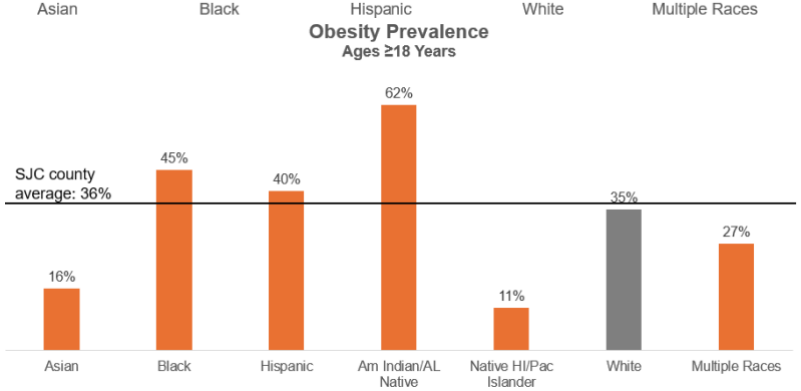
Chronic Disease/Healthy Eating Active Living (HEAL)

Rationale: Why this is a critical health need

Chronic diseases are primary causes of poor health outcomes and death and a leading driver of health care costs. Residents with limited access to healthy foods have a higher risk of developing a chronic disease, such as obesity, heart disease, diabetes, or asthma. Along with a healthy diet, physical activity is key to preventing and reducing complications from chronic diseases. This exploration of chronic disease focuses on the most common chronic conditions causing illness and death and does not include many other chronic conditions, including autoimmune diseases.

Chronic disease*	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA**
Poor physical health (days per month)	Yes	N/A	↓
Poor or fair health (ages 18+ yrs)	Yes	Yes	↓
Heart disease hospitalizations	Yes	Yes	↓
Heart disease deaths	Yes	No	↓
Stroke hospitalizations	No	Yes	↓
Stroke deaths	Yes	No	↓
Diabetes prevalence (ages 18+ yrs)	Yes	Yes	↑
Asthma prevalence (all ages)	No	Yes	-
Asthma prevalence (ages 0-17 yrs)	Yes	Yes	↑↑
Colorectal cancer incidence	Yes	Yes	↑↑
Lung cancer incidence	Yes	Yes	↓
HEAL opportunities*			
Obesity (ages 18+ years)	Yes	Yes	↑
Physical inactivity (ages 18+ years)	Yes	N/A	↓
Exercise opportunities	Yes	N/A	↑





* Table includes selected indicators that are worse than CA average or illustrate disparities

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Key findings and disparities across San Joaquin County (based on health data)

- SJC residents have significantly (30%) more days per month of poor physical health than the CA average.
- The heart disease death rate in SJC is higher than CA overall (149 versus 142 per 100,000, respectively), and death from stroke (49 per 100,000) is 26% higher in SJC than CA (39 per 100,000).

- Black/African American SJC residents have the highest rates of hospitalization for cardiovascular disease; they are almost 35% more likely to be admitted to the hospital for heart disease and over 35% more likely to be admitted for stroke than White residents.
- Adults in SJC are significantly more likely to have a diabetes diagnosis (15%) than all California adults (11%). White adults are less likely to have diabetes than Black/African American, Hispanic, and Asian SJC residents.
- Pediatric asthma prevalence (24%) in SJC is almost twice that of the CA average (13%), with Black/African American (39%) and Hispanic (34%) children experiencing significantly higher rates than White children (16%).
- Black/African American SJC residents have the highest incidence of colorectal and lung cancer among all ethnicities/races; 19% and 12% higher, respectively, compared to White residents.
- Approximately 36% of adults in SJC experience obesity, compared to 28% across CA; Black/African American (45%), Hispanic (40%), and American Indian/Alaskan Native (62%) SJC adults have significantly higher rates of obesity than White adults (35%).
    - The Black/African American and American Indian/Alaskan Native communities experienced a disproportionate increase (by 28% and 54% respectively) in their rates of obesity since the 2022 CHNA compared to their White neighbors (14% increase).

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 12 of 14 Priority Neighborhoods have a lower average age of death than SJC overall.
- Heart disease is one of the top 5 causes of death in all Priority Neighborhoods.
- The rates of death due to cancer and Alzheimer's disease have more than doubled in CT 16 since the 2022 CHNA.

What community stakeholders say about chronic disease/HEAL (based on key informant interviews and focus groups)

Overall

- 28% (11 of 40) focus groups and 5 of 10 key informants identified chronic disease as a top priority health need in SJC.
- 50% (20 of 40) focus groups identified HEAL opportunities as a top priority health need in SJC, and 4 of 10 key informants mentioned it.
- Focus group participants and key informants ascribed high chronic disease rates to the pervasive presence of unhealthy processed/fast foods, lack of affordable healthy foods, food deserts, community barriers to physical activity, and limited access to healthcare.
- Key informants asserted that too few resources are available for chronic disease prevention.
- High cost healthy foods and low cost convenience/fast foods present major barriers to healthy eating, according to focus group participants, who noted that grocery stores offering affordable, appealing produce are not available in all communities.
- Focus group participants identified multiple barriers to outdoor physical activity in parks/public spaces: gun violence, gang activity, drug use/paraphernalia, unhoused camps, hazardous driving, limited lighting, trash, and incomplete bike routes/lanes.

> "We know that it [diabetes prevention] is trigger behavior – if a loved one gets really sick or loses a foot, they all of a sudden pay attention. But otherwise, it's very difficult to get traction for that issue." – *Public health official*

Disparities

- Focus group participants perceived that diabetes, heart disease, obesity and asthma are most common in Black/African American and Hispanic/Latino neighborhoods.
- Key informants highlighted diabetes disparities, noting that certain racial/ethnic groups and low-income communities are disproportionately impacted; effective prevention and treatment services must be affordable, provided in the languages of affected populations, and located in venues/formats that make access easy for busy individuals/families.
- Focus group participants reported that low-income residents, people of color, and immigrants are more likely to live in communities that are food deserts and lack gyms/indoor recreation spaces or parks for regular physical activity.

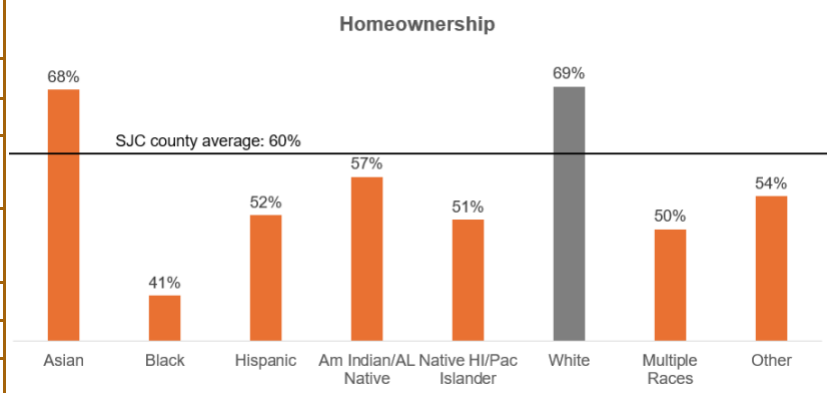
> "In certain neighborhoods, it's not that easy to get good access [to healthy foods] without getting on a bus or in your car. We have some food deserts where there's not great access to fresh food."– *Community based organization leader*

Housing

Rationale: Why this is a critical health need

The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30 percent of a household's income. Higher expenditures can result in the household being unable to afford other necessities such as food, clothing, transportation, and medical care. The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside. Homelessness is correlated with poor health: poor health can lead to homelessness and homelessness is associated with greater rates of preventable diseases, longer hospital stays, and greater risk of premature death. When compared to California overall, measures of housing in SJC fare better than state averages; however, this comparison is distorted due to the overall high cost of housing in California and masks the housing challenges and instability that exist in SJC, especially in the Priority Neighborhoods.

Housing	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Homeownership	No	Yes	↑
Uncrowded housing	No	Yes	↓
Low-income renters (Severe housing cost burden)	No	NA	↓
Low-income Homeowner (Severe housing cost burden)	No	NA	↑
Severe housing cost burden	No	NA	↓
Median rental cost	No	NA	↑
Housing Habitability	No	NA	-
Housing affordability index	No	NA	↓↓
Percent of income for mortgage	No	NA	↑↑



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Key findings and disparities across San Joaquin County (based on health data)

- Median rental costs in SJC remain lower than CA overall, but the median rental cost in SJC has increased by approximately 10% to $1,527 since the 2022 CHNA.
- While the homeownership rate in SJC is better than CA overall, for most SJC residents of color homeownership rates are significantly lower. Residents of all racial/ethnic groups -- except Asian -- are significantly less likely to own their home than their White neighbors.

- Rates of uncrowded housing in SJC are similar to the CA average, but compared to White residents, all other SJC racial/ethnic groups have a higher percentage living in crowded housing.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- Half (7) of the Priority Neighborhoods experienced a decrease in housing habitability since the 2022 CHNA.
- 12 of 14 Priority Neighborhoods have lower rates of homeownership compared to SJC.
- CT 22.01 has the lowest rate (87%) of housing habitability among the Priority Neighborhoods.

What community stakeholders say about housing (based on key informant interviews and focus groups)

Overall

- 40% (16/40) of focus groups and 2 of 10 key informants identified housing as a top priority health need in SJC.
- Focus group participants and key informants agreed that the lack of affordable housing in SJC is severe, reporting that most affordable housing options are in unsafe neighborhoods or provide unhealthy living conditions.
- Prohibitively high housing costs contribute to stress and reduce available financial resources for health needs, according to focus group participants and key informants.
- Key informants pointed out that skyrocketing housing costs have increased the number of residents at risk for housing instability or homelessness, and county housing assistance programming/services are not keeping pace with demand to support middle-income families now at risk.
- Focus group participants described homelessness as a significant problem in SJC; state/local governments' efforts to address the county's unhoused population were perceived as ineffective.
- Finding a living space for the unhoused is only part of the solution, according to key informants. Many unhoused individuals require additional supports, services, treatments, and/or rehabilitation to decrease risk of returning to transiency or homelessness.

> "Why isn't the government helping those who are on the street?" – *Focus group participant*

Disparities

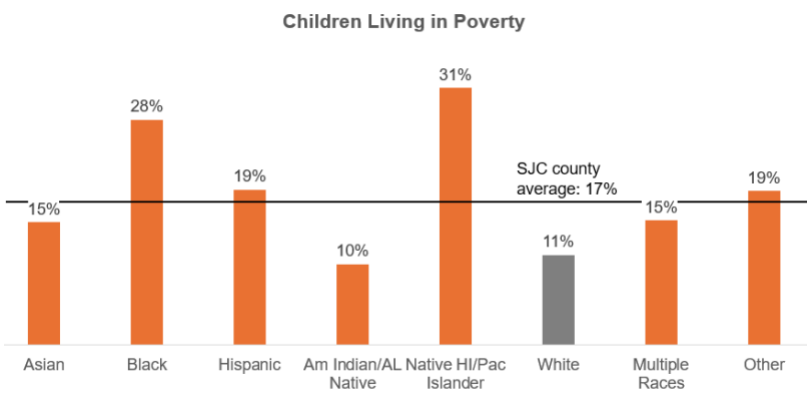
- Focus group participants and key informants stated that low- and middle-income residents (especially people of color, immigrants, migrants, older adults, people with special needs, urban residents, and single parents) are most impacted by rising housing costs, struggle to obtain housing assistance, and require expanded services tailored to meet their specific needs.
- Homelessness in SJC disproportionately affects people of color, those with mental health and substance use challenges, undocumented immigrants, and LGBTQIA+ individuals, according to key informants.

Economics

Rationale: Why this is a critical health need

People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of well-resourced schools and an adequate concentration of well-paying jobs. Childhood poverty has long-term effects; even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The establishment of policies that positively influence economic conditions can create sustainable improvements in the physical and mental health of individuals and communities.

Economic	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Income	Yes	Yes	↑
Employed (ages 16+)	Yes	Yes	↑
Jobs Proximity Index	No	N/A	N/A
Income inequality – Gini Index	No	N/A	N/A
Living in poverty (<100% Fed Poverty Level)	Yes	Yes	↓
Seniors (ages 65+ years) living in poverty	No	Yes	↑
Children living in poverty	Yes	Yes	↓
Young people not in school and not working	Yes	N/A	↑
High speed internet	Yes	Yes	↑



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Key findings and disparities across San Joaquin County (based on health data)

- Among SJC residents, average yearly income ($83,000) is almost 10% less than the CA average ($92,000); average income for White SJC residents is close to the CA average, but Hispanic ($74,000), Black/African American ($65,000), American Indian/Alaskan Native ($77,000), and Multiethnic ($77,000) residents earn significantly less.
    - Average income in SJC has increased by almost $20,000 since the 2022 CHNA, and all racial/ethnic groups' average incomes have increased as well, but not enough to eliminate income disparities.
- 70% of SJC residents aged 16 and older are employed, significantly lower than statewide (73%).

- The poverty rates in SJC for all residents (13%) and for children (17%) are significantly higher than the CA averages (12% and 16%, respectively).
    - All racial/ethnic groups in the county, except for American Indian/Alaska Native residents, have significantly higher poverty rates for all residents/children than White SJC residents.
- SJC older adults (aged 65 and older) who are Black/African American (15%), Hispanic (15%), American Indian/Alaskan Native (14%), and Native Hawaiian/Pacific Islander (47%) are significantly more likely to be impoverished than their White neighbors (9%).
- High-speed Internet access (90%) among SJC residents is significantly lower than the CA average (92%); Black/African American residents have the lowest percentage of Internet connectivity.
    - Internet access has increased in SJC almost 10% since the 2022 CHNA, with all racial/ethnic groups experiencing some increase.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 12 of 14 Priority Neighborhoods have lower average incomes than SJC overall.
- 13 of 14 Priority Neighborhoods have higher rates of people living in poverty than in SJC.
- CTs 1.01/1.02 have the lowest percentage (27%) of employed adults among the Priority Neighborhoods; adult employment has substantially decreased since the 2022 CHNA.

What community stakeholders say about economics (based on key informant interviews and focus groups)

Overall

- 13% (5/40) of focus groups and 3 of 10 key informants identified economics as a top priority health need in SJC.
- Recent inflation and the high cost of living was perceived by focus group participants and key informants as detrimental to health; focus group participants asserted that working long hours and/or multiple jobs to meet expenses leaves little time/energy to address mental or physical health needs.
- Focus group participants and key informants stated that obtaining employment or regaining economic stability has been difficult after pandemic-related job losses.
- Due to inflation/job loss, focus group participants noted that residents who were recently comfortably middle-income now frequently struggle with expenses but do not qualify for assistance and services.

Disparities

- People of color, older adults, and unhoused individuals experience disparities in employment, according to focus group participants, resulting in lower incomes that negatively impact health.
- Rising health care costs disincentivize individuals and families, especially lower income residents, from seeking preventive health care and/or treatment; key informants reported that residents often seek medical care only when a health problem is exacerbated, resulting in expensive emergency care.

> "There was always a lot of manual jobs out there. We started as an organization for migrant seasonal farm workers and there were tons of jobs. There are not tons of farm jobs anymore or manual jobs." – *Community Based Organization Leader*

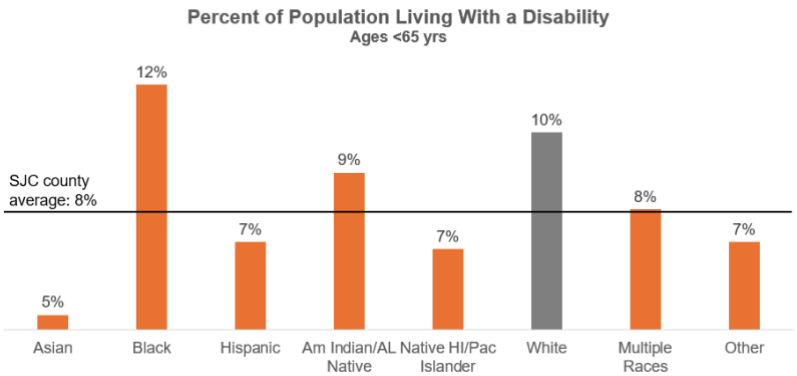
> "There is no opportunity for homeless people who do want to work or do something, but don't know how or can't. I mean, who's gonna give us a shot at it?" – *Focus group participant*

Social Support

Rationale: Why this is a critical health need

The presence or absence of a strong social support network affects all aspects of life, including physical and mental well-being; social connections provide emotional support that assists in responding to life challenges and difficulties. Loneliness has been associated with a wide variety of health problems including heart disease, poor immunity, and cognitive decline. Communities are the context in which individuals and families prosper or struggle, highlighting the importance of leveraging community resources to foster social connections.

Social Support	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Limited English proficiency	Yes	Yes	↑
Disability Population (ages <65 years)	No	Yes	↓
Disability Population (all ages)	No	N/A	↓
Seniors living alone (ages 65+ years)	No	N/A	↓
Two parent households	No	N/A	↑



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Key findings and disparities across San Joaquin County (based on health data)

- Limited English proficiency is higher in SJC (41%) as compared to the CA average (39%).
    - Since the 2022 CHNA, rates of limited English proficiency have increased among almost all racial/ethnic groups in SJC, except for Native Hawaiian/Pacific Islanders.
- Approximately 12% of SJC residents of all ages are living with a disability, including 8% of younger adults. Among residents under age 65, Black/African American SJC residents (12%) have the highest disability rate.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 11 of 14 Priority Neighborhoods have a smaller percentage of two parent households than SJC overall.
- All 14 Priority Neighborhoods experienced an increase in individuals with limited English proficiency since the 2022 CHNA; 9 Priority Neighborhoods experienced a 75% or greater increase.

- CT 3 faces substantial social support challenges with the lowest percentage (33%) of two parent households and the highest rate (69%) of individuals with limited English proficiency among the Priority Neighborhoods.

What community stakeholders say about social support (based on key informant interviews and focus groups)

Overall

- 13% (5 of 40) of focus groups and 1 of 10 key informants identified social support as a top priority health need in SJC.
- Focus group participants and key informants agreed that many SJC families need more support with caring for children, loved ones with disabilities, and older adults.
- Residents (particularly older adults and children) are experiencing increased isolation and loneliness, according to focus group participants, which has persisted post-pandemic. Key informants perceived that there are fewer opportunities for in-person gatherings in the post COVID-19 era.
- Key informants noted that the pandemic caused many children to lose or delay development of age-appropriate social skills, leaving parents and families to grapple with the aftermath.
- Young adults aging out of the foster care system lack appropriate supports; focus group participants perceived that more services are needed to maximize their potential.

Disparities

- Key informants reported that obtaining and affording childcare is a significant challenge for many families in rural communities, which limits parents' employment opportunities because they need to stay home to care for their children.

"Families who…take care of their adult children [with disabilities] who have needs, those families struggle...there's no board and care facility or my board and care facility shut down or...the cost is not affordable." – *Community based nonprofit leader*

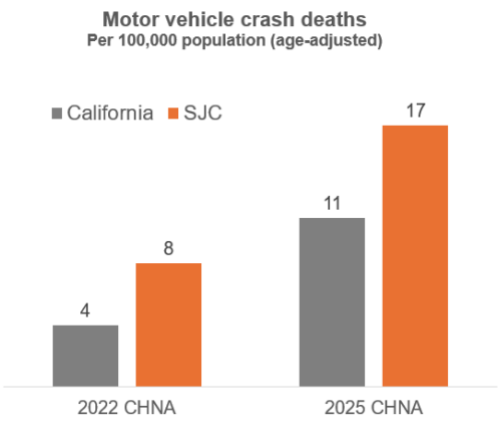
"Childcare was the biggest barrier to staying/getting back into workforce. They couldn't afford it or it's just not available." – *Healthcare leader*

Community Safety

Rationale: Why this is a critical health need

Safe communities promote social interaction, economic development, and opportunities to be active, while reducing untimely deaths and serious injuries. Crime, violence, and intentional injury are related to worse physical and mental health outcomes for victims, perpetrators, and the community at large. Communities that have been systematically marginalized experience higher rates of violence. Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes. In addition, the physical and mental health of youth of color—particularly males—is disproportionately affected by juvenile arrests and incarceration related to policing practices. Motor vehicle crashes, pedestrian accidents, and falls are common causes of unintended injuries, lifelong disability, and death.

Community safety	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Premature death (Years of potential life lost before age 75 per 100,000 population)	Yes	N/A	↑
Violent crimes	Yes	N/A	↓
Unintentional injury deaths	Yes	No	↑
Motor vehicle crash deaths	Yes	No	↑↑↑↑
Pedestrian accident deaths	No	No	↑



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Key Findings and Disparities Across San Joaquin County (based on health data)

- SJC residents experience significantly more premature deaths than CA overall, with over 30% more years of potential life lost (YPLL) before age 75 among SJC residents compared to residents statewide.
    - The YPLL in SJC had increase by 14% since the 2022 CHNA, indicating that the number of premature deaths has increased in the county.
- Violent crime is nearly 40% higher in SJC than CA overall; however, the rate of violent crime has decreased in SJC since the 2022 CHNA by about 14%.
- The number of unintentional injury deaths in SJC (69 per 100,000 population) is significantly higher than CA overall (55 per 100,000 population).

- Motor vehicle crash deaths are more than 50% higher in SJC (17 per 100,000 population) than statewide (11 per 100,000 population).
    - The number of motor vehicle crash deaths in SJC has more than doubled since the 2022 CHNA, from 8 per 100,000 population to 17 per 100,000 population.

What community stakeholders say about community safety (based on key informant interviews and focus groups)

Overall

- 30% (12/40) of focus groups and 1 of 10 key informants identified community safety as a top priority health need in SJC.
- Focus group participants and key informants agreed that residents' perceived lack of community safety in public and outdoor spaces, like parks, limits their ability to be physically active.
- Key informants listed the types of violence/criminal activity that are commonly experienced, such as interpersonal aggression, domestic abuse, and illegal substance use, as well as fear of violence.
- Key informants also mentioned how frequent yet seemingly smaller issues, like speeding cars or stray dogs, negatively impact health by discouraging outdoor physical activities.
- Children's safety was a concern voiced by focus group participants; many streets/parks/outdoor recreation areas were deemed unsafe due to gang/criminal activity, substance use, blight, and the presence of unhoused individuals.
- For older adults, safety concerns pose barriers to engaging in the community, according to focus group participants, resulting in isolation and less ability to access necessary services and healthcare.

> "We've had multiple people sent to the hospital for dog bites. And we've had a lot of people not willing to go outside because of stray dogs." – *Community Based Organization Leader*

Disparities

- Focus group participants reported that low income/historically underserved neighborhoods experience reckless driving, deteriorating infrastructure, and gun violence, but often receive fewer community safety resources/investment from government/law enforcement.

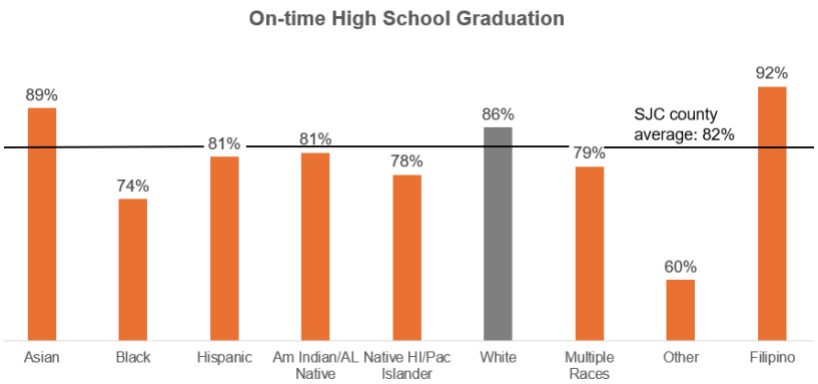
> "Downtown to the south side [of Stockton] I feel is being just left alone [by law enforcement]." – *Focus group participant*

Education

Rationale: Why this is a critical health need

The link between education and health is well known — individuals with higher levels of education are more likely to be healthier and live longer. Pre-school education is positively associated with readiness for and success in school, and has long-term benefits for individuals and society, including greater educational attainment, higher income, and lower engagement in delinquency and crime. Individuals with at least a high school diploma do better on several measures, including income, health outcomes, life satisfaction, and self-esteem. Wealth among families in which the head of household has a high school diploma is 10 times higher than that of families in which the head of household didn't complete high school. Moreover, the majority of jobs in the U.S. require education beyond high school.

Education	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Preschool enrollment	Yes	NA	↓
High school enrollment	No	NA	↓
Students proficient in math	Yes	Yes	↓
Students proficient in reading	Yes	Yes	↓
On-time high school graduation	Yes	Yes	↑
Adults with no high school diploma	Yes	Yes	↓
Adults with some college education	No	Yes	↑
Bachelor's education or higher	Yes	Yes	↑



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Key findings and disparities across San Joaquin County (based on health data)

- The percentage of children enrolled in preschool in SJC (38%) is significantly lower than the CA average (45%).
    - Preschool enrollment in SJC has decreased since the 2022 CHNA by 13%.
- Students in SJC have significantly lower rates of proficiency in math (27%) and reading (40%) than students across CA (35% and 47%, respectively) and SJC Hispanic, Black/African American, and Multiethnic students have significantly lower proficiency in math and reading compared to White SJC students.
- The on-time high school graduation rate for SJC students (82%) is significantly lower than the CA average (86%); Black/African American students (74%) have significantly lower rates of on-time graduation than White students (86%).

- Only 9% of Hispanic adults and 19% of Black/African American adults in SJC have completed a college education, compared to 25% of White adults.
    - The percentage of adults who have completed a college education in SJC has increased since 2022 across all racial/ethnic groups except for Multiracial adults.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 12 of 14 Priority Neighborhoods have higher percentages of adults without a high school diploma than SJC overall.
- 13 of the 14 Priority Neighborhoods have smaller percentages of individuals with a bachelor's education or higher than SJC.
- CT 47.01 has the lowest rate (7%) of preschool enrollment among the Priority Neighborhoods.

What community stakeholders say about education (based on key informant interviews and focus groups)

Overall

- 13% (5 out of 40) of focus groups and 2 of 10 key informants identified education as a top priority.
- Focus group participants noted that lasting pandemic impacts on education quality have resulted in unmotivated, less educated students who are more prone to behavioral issues, mental health concerns, substance use (especially vaping), and violence.
- Key informants want more support for career development and readiness at all educational levels, beginning in early childhood and continuing through young adulthood.
- Effective health education requires more than passing out information in various languages or pointing out websites, suggested key informants; they recommended aligning health information to community cultural norms and values and discussing health education in person.

> "We are going to have to help education, they can't solve it alone. So many of the things that plague our community - having kids properly cared for in preschool sets them up for success in schools, in their career or college pathway. – *Community Based Organization Leader*

Disparities

- Students from marginalized/low-income neighborhoods are disproportionately impacted by under resourced schools, according to focus group participants.
- Focus group participants emphasized that students of color, especially Black/African American children and teens, face societal and structural challenges in educational environments, are more likely to receive disciplinary action and are less likely to receive academic support.
- Healthcare providers who receive graduate education and training within the SJC communities they serve, or who receive continuing education relevant to their communities, are better positioned to connect with patients and encourage ongoing healthcare, according to key informants, especially within populations that have historically been underserved or even mistreated by the medical system.

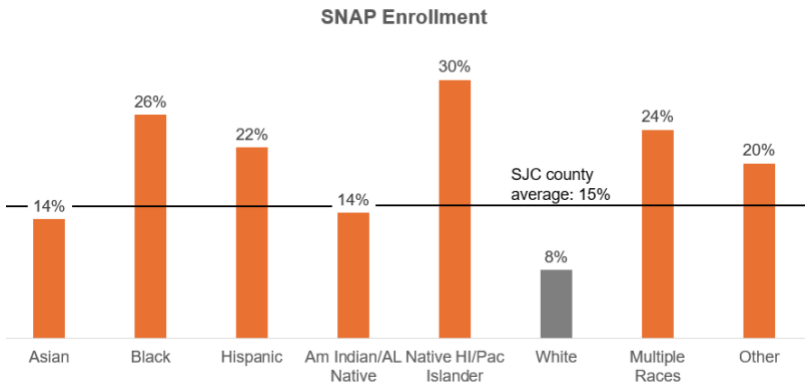
> "We can make beautiful pamphlets with all the information. We meet them where they are, like elementary school, or we can go to the parishes. If you hand out flyers, it's like Charlie Brown's teacher. A lot of them have too much verbiage. So it's just getting out there and educating them one-on-one." – *Community Based Organization Leader*

Food Security

Rationale: Why this is a critical health need

Many individuals and families, especially those with financial or transportation challenges, struggle to consistently access the kinds of foods that support health and wellness. The link between food insecurity and chronic diseases related to diet is well established. Poor diet is a prominent risk factor for chronic health conditions, which are prevalent, deadly, and costly.

Food security	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
SNAP enrollment	Yes	Yes	↑
Free and reduced-price lunch	Yes	N/A	↑
Convenience stores per 1,000 population	No	N/A	N/A
Grocery stores per 1,000 population	No	N/A	N/A
Low access to grocery store	No	N/A	–
Food insecure	No	N/A	↓



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Key findings and disparities across San Joaquin County (based on health data)

- The percentage of SJC residents (15%) relying on SNAP (food assistance) to afford food is almost 50% higher than the statewide rate (10%). County residents of all racial/ethnic groups (except for Asian) have nearly double or even triple the rate of SNAP enrollment compared to white SJC residents.
    - Since the 2022 CHNA, SNAP enrollment has increased in SJC overall and for most racial/ethnic groups. Only American Indian/Alaska Native and White populations have experienced slight decreases.
- A higher percentage of SJC students (66%) qualify for free and reduced-price lunch (FRPL) as compared to California overall (62%).
    - More SJC students (66%) qualify for FRPL currently as compared to the 2022 CHNA (57%) – a 17% increase.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 11 of 14 Priority Neighborhoods have higher rates of SNAP (food assistance) enrollment than SJC.
- SNAP enrollment increased in 9 of 14 Priority Neighborhoods since the 2022 CHNA.
- Over half (51%) of CT 33.12 residents are enrolled in SNAP, more than three times higher than SJC overall.

What community stakeholders say about food security (based on key informant interviews and focus groups)

Overall

- 10% (4 of 40) of focus groups identified food security as a top priority health need in SJC, and 6 of 10 key informants mentioned it as a health need.
- Key informants and focus group participants reported that the need for food assistance is increasing due to post-pandemic economic impacts and resulting inflation.
- Focus group participants and key informants described the difficult choices that many SJC residents frequently encounter buying food or affording bills, healthcare, or other necessities of daily living.
- Focus group participants listed a variety of accessible sources for food assistance, including schools, libraries, churches, government, and community organizations.
- Existing SJC food banks and food distribution programming meet some of the need for food assistance, but key informants stated that these programs should be expanded to better meet the demand.

> "We see our families making choices between prescriptions and food. And we wonder why they don't go for health care appointments. But these are the choices they are making."
>
> *– Community based nonprofit leader*

Disparities

- Key informants pointed out the link between chronic diseases and the inability to access food, especially healthy food, and the disproportionate impact on vulnerable populations, such as older adults or low-income residents without vehicles.

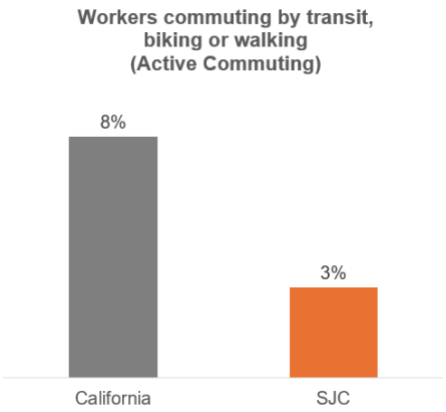
> "Food insecurity ties so closely to diabetes...Through 211 and Door Dash, we have those food boxes delivered to people that don't have transport, like seniors who can't drive. Those kinds of partnerships are important for diabetes and other issues."
> *– Community based nonprofit leader*

Transportation

Rationale: Why this is a critical health need

Without reliable and safe transportation, individuals struggle to meet basic needs, such as earning an income, accessing health care, and securing food. Transportation infrastructure favors automobile use, which is associated with several adverse outcomes, including motor vehicle injuries and deaths, vehicle ownership expenses, and greenhouse gas emissions (which are a risk factor for heart disease, stroke, asthma, and cancer.) For households without a vehicle - including many low-income individuals and people of color - walking, biking, and using public transportation provides a critical link to employment, increases access to essential services, promotes exercise, and supports social cohesion.

Transportation	SJC Performs Significantly Worse than CA	Ethnic/Racial Disparities Present in SJC	Change Since 2022 CHNA*
Workers driving alone to work	Yes	Yes	↑
Workers driving alone with long commutes	Yes	N/A	↑
Workers commuting by transit, biking or walking (Active Commuting)	Yes	N/A	↓
Retail density	Yes	N/A	N/A
Automobile Access	No	N/A	↑



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Key findings and disparities across San Joaquin County (based on health data)

- Significantly more SJC workers (83%) drive alone to work than in CA overall (79%); workers of most races/ethnicities have lower rates of driving to work alone than their White colleagues.
- Workers in SJC are almost twice as likely to drive alone with long commutes (20%) than statewide (11%).
    - Since the 2022 CHNA, the rate of SJC workers driving alone with long commutes has increased (approximately 9%).
- Far fewer SJC workers actively commute by transit, biking, or walking (3%) than in CA overall (8%).
    - SJC and statewide rates of active commuting have dropped slightly since the 2022 CHNA.

Communities disproportionately impacted (based on Priority Neighborhood Profiles)

- 10 of 14 Priority Neighborhoods have lower rates of automobile access than SJC overall.

- 6 of 14 Priority Neighborhoods have low rates of active commuting compared to SJC.
- The automobile access rate of CTs 1.01/1.02 is approximately half the SJC average (54% vs 95%).

What community stakeholders say about transportation (based on key informant interviews and focus groups)

Overall

- 8% (3/40) of focus groups and 4 of 10 key informants identified transportation as a top priority health need in SJC.
- Focus group participants stated that transportation barriers make meeting basic needs difficult, jeopardizing food security and access to health care.
- Key informants specified that barriers to active transportation include crime and lack of infrastructure that supports biking and walking.

Disparities

- Although focus group participants expressed appreciation for the public transportation that is currently available within the county, key informants noted that, even in urban SJC communities, available public transportation systems are inadequate to meet residents' needs.
- Key informants also pointed out that rural residents have few options for transportation into urban centers.
- Focus group participants suggested providing affordable or free transportation for patients in need of medical services and for low-income residents.

"Stockton...it's not a walkable city. There are very nice paths in certain areas, but the city has not been planned to encourage walking. And it's sad that it's not a bike city, because it's as flat as can be but there is very minimal biking. Commuting would be dangerous because drivers are crazy, and the streets are dangerous." – *Community Based Organization Leader*

"We are seeing a big need especially in rural areas; if you live on the outskirts of town, getting to those doctors' appointments can be a challenge." – *Community Based Organization Leader*

VIII. Appendices

A. CHNA Secondary Data Indicator Definitions, Data Sources and Dates
B. San Joaquin County CHNA Secondary Data Table
C. Community Input Tracking Form
D. Key Informant Interview Guide
E. Focus Group Screener and Guide
F. Annotated Bibliography of San Joaquin County Reports and Assessments
G. Community Resources

Appendix A: CHNA Secondary Data Indicator Definitions, Data Sources and Dates

Health Topic	Measure	Definition	Data Source, Year
Access to care	Low Birth Weight Births	Low birth weights are defined as less than 5 pounds, and 8 ounces (2,500 grams).	VRBIS, 2019-2023 (Birth Certificate)
	Prenatal Care in 1st Trimester (per 100 live births)	Trimester means "3 months." A normal pregnancy lasts around 10 months and has 3 trimesters. Prenatal care in the 1st Trimester would be the first 3 months.	VRBIS, 2019-2023 (Birth Certificate)
	Pre-Term Births	Preterm birth is when a baby is born too early, before 37 weeks of pregnancy have been completed.	VRBIS, 2019-2023 (Birth Certificate)
	Dentists per 100,000 population	Number of Dentists per 100,000 population	KP 2025 Community Health Needs Dashboard
	Infant Deaths (per 1000 live births)	(VRBIS Deaths under 1 year of age/5)/(VRBIS live births/5)	VRBIS, 2019-2023 (Birth & Death Certificate)
	Insured (ages 19-64 years)	Percentage of adults ages 19-64 currently insured	US Census, ACS 2022 (5-year Estimates Data Profiles)
	Medicaid/Public Insurance Enrollment	Percentage of the population enrolled in Medicaid or another public health insurance program	US Census, ACS 2022 (5-year Estimates Data Profiles)
	Primary Care Physicians per 100,000 population	Number of Primary care physicians per 100,000 population	KP 2025 Community Health Needs Dashboard
	Uninsured Children	Percent of children under the age of 19 without health insurance coverage	US Census, ACS 2022 5-year Estimates Subject Tables (State/County/Priority Neighborhood Tracts)

Health Topic	Measure	Definition	Data Source, Year
			US Census, ACS 2022 1-year Estimates Subject Tables (Race/Ethnicity)
Cancer	Lung cancer incidence	Lung and Bronchus Cancer, Age-Adjusted Incidence Rates, All Stages, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	All Cancer Sites Combined	All Cancer Sites Combined, Age-Adjusted Incidence Rates, All Stages, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	Breast cancer incidence	Breast Cancer, Age-Adjusted Incidence Rates, All Stages, Female, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	Colorectal cancer incidence	Colon Cancer, Age-Adjusted Incidence Rates, All Stages, All Ages, By Race/Ethnicity, 2017-2021	California Cancer Registry, 2017-2021
	Prostate cancer incidence	Prostate Cancer, Incidence, County Rates, Compare By Race/Ethnicity, Male, All Ages, Year of Diagnosis: 2017-2021	California Cancer Registry, 2017-2021
	Cancer Deaths (age adjusted per 100,000)	State v County, All Sites age adjusted cancer death rate/100,000 population 2020-2022; Census tract and Race/Ethnicity, All Sites cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Breast cancer deaths	State v County, Female breast cancer age adjusted death rate/100,000 female population 2020-2022; Census tract and Race/Ethnicity, Breast cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Colorectal cancer deaths	State v County, Colorectal cancer age adjusted death rate/100,000 population 2020-2022; Census tract and	CDPH - County Health Status Profiles (2024)

Health Topic	Measure	Definition	Data Source, Year
		Race/Ethnicity, Colorectal cancer death rate/100,000 population 2018-2022	VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Lung cancer deaths	State v County, Lung cancer age adjusted death rate/100,000 population 2020-2022; Census tract and Race/Ethnicity, Lung cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
	Prostate cancer deaths	State v County, Prostate cancer age adjusted death rate/100,000 male population 2020-2022; Census tract and Race/Ethnicity, Prostate cancer death rate/100,000 population 2018-2022	CDPH - County Health Status Profiles (2024) VRBIS Cancer Deaths, 2018-2022 2019 ACS 5 year population estimate
Chronic disease	Asthma prevalence (0-17 years)	Topic: Ever diagnosed with asthma ("Respondents were asked: "Has a doctor ever told you that you have asthma?")	askCHIS, 2018-2022 (pooled)
	Asthma ED Visits (0-17 years)	Asthma ED Visits Rate per 10,000 population, 2019	California Breathing, County Asthma Data Tool
	Asthma ED Visits (all ages)	Asthma ED Visits Rate per 10,000 population, By Race/Ethnicity, 2019	California Breathing, County Asthma Data Tool
	Asthma Hospitalizations (0-17 years)	Asthma Hospitalization Rate per 10,000 population, 2019	California Breathing, County Asthma Data Tool
	Asthma Hospitalizations (all ages)	Asthma Hospitalization Rate per 10,000 population, By Race/Ethnicity, 2019	California Breathing, County Asthma Data Tool

Health Topic	Measure	Definition	Data Source, Year
	Asthma prevalence (all ages)	Topic: Ever diagnosed with asthma ("Respondents were asked: "Has a doctor ever told you that you have asthma?")	askCHIS, 2018-2022 (pooled)
	Diabetes prevalence (ages 18+ years)	Topic: Ever diagnosed with diabetes ("Respondents were asked: "{Other than during pregnancy, had/Has} a doctor ever told you that you have diabetes or sugar diabetes?")	askCHIS, 2018-2022 (pooled)
	Heart Disease Deaths (age adjusted rate per 100,000)	((VRBIS Heart Disease Deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023 (Death Certificate)
	Heart Disease Hospitalizations	Heart Disease Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+, All Races/Ethnicities, Both Genders, 2019-2021	Interactive Atlas of Heart Disease and Stroke, 2019-2021
	Heart disease prevalence (ages 18+ years)	Topic: Ever diagnosed with heart disease (Respondents were asked "Has a doctor ever told you that you have any kind of heart disease?")	askCHIS, 2018-2022 (pooled)
	Poor physical health (days per month)	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	County Health Rankings & Roadmaps, 2024 Behavioral Risk Factor Surveillance System (BRFSS), 2021
	Poor or fair health (ages 18+ years)	Topic: Health status (Respondents were asked: "In general, would you say your health is excellent, very good, good, fair or poor?")	askCHIS, 2018-2022 (pooled)
	Stroke Deaths (age adjusted rate per 100,000)	((VRBIS Stroke Deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023 (Death Certificate)

Health Topic	Measure	Definition	Data Source, Year
	Stroke Hospitalizations	Stroke Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+, All Races/Ethnicities, Both Genders, 2016-2018 NOTE: California rate was not updated from 2022 CHNA	Interactive Atlas of Heart Disease and Stroke, 2019-2022
	Stroke prevalence	Estimated percent of adults ever diagnosed with a stroke, Aged 18+ yrs, 2021	Interactive Atlas of Heart Disease and Stroke, 2021
Climate and environment	Air Pollution: PM2.5 Concentration	Past: Annual mean concentration of PM 2.5 (weighted average of measured monitor concentrations and satellite observations, µg/m3), over three years (2015-2017). Current: Annual mean concentration of PM 2.5 (weighted average of measured monitor concentrations and satellite observations, µg/m3), over three years (2015-2017).	CalEnviroscreen 4.0 California Air Resources Board (CARB)
	Coastal Flooding Risk	A Coastal Flooding annualized frequency value represents the modeled frequency of Coastal Flooding hazard occurrences (events) per year.	KP 2025 Community Health Needs Dashboard
	Drought Risk	Deficiency of precipitation over an extended period of time resulting in a water shortage	FEMA National Risk index
	Heat Wave Risk	A period of abnormally and uncomfortably hot and unusually humid weather typically lasting two or more days with temperatures outside the historical averages for a given area.	FEMA National Risk index
	River Flooding Risk	A Riverine Flooding annualized frequency value represents the average number of recorded Riverine Flooding hazard occurrences (event-days) per year over the period of record (24 years)	KP 2025 Community Health Needs Dashboard
	Water Contaminants	Past: n/a Current: Drinking water contaminant index for selected contaminants (2011 to 2019)	CalEnviroscreen 4.0

Health Topic	Measure	Definition	Data Source, Year
			Drinking water contaminant index for selected contaminants (2011 to 2019)
	Urban Tree Canopy	Percent canopy 2018 by urban census tracts	USDA Forest Service
	Road Network Density	Number of interconnected roads in a given area.	KP 2025 Community Health Needs Dashboard
Community safety	Unintentional Injuries Deaths (Age adjusted rate per 100,000)	Age adjusted death rate of deaths due to unintentional injuries	VRBIS 2019-2023
	Motor Vehicle Traffic Deaths (Age adjusted rate per 100,000)	Age Adjusted death rate of deaths caused by motor vehicle crashes	VRBIS 2019-2023
	Pedestrian Accident Deaths (Age adjusted rate per 100,000)	Age adjusted death rate of pedestrian accidents	VRBIS 2019-2023
	Premature Death (YPLL)	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	County Health Rankings & Roadmaps, 2024 The 2024 County Health Rankings used data from 2019-2021 for this measure.
	Violent Crimes	Total Number of Violent Crimes reported per 100,000 population, 2019	State of California Department of Justice, 2022
Demographics	% American Indian/Alaska native population	Percent of the total population that identify as American Indian/Alaska native, non-Hispanic	2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
	% Asian population	Percent of the total population that identify as Asian, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Black/African American population	Percent of the total population who identify as Black or African American, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Hispanic/Latino population	Percent of the total population that identify as ethnically Hispanic/Latino	2022: ACS 5-year Estimates Data Profiles
	% Multiracial population	Percent of the total population that identify as multiple races, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Native Hawaiian/other Pacific Islander population	Percent of the total population that identify as Native Hawaiian/other Pacific Islander, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% Some other race population	Percent of the total population that identify as some other race, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	% White population	Percent of the total population that identify as White, non-Hispanic	2022: ACS 5-year Estimates Data Profiles
	Life expectancy	The average number of years a person can expect to live at birth	County Health Rankings, 2024
	Average Age of Death	n/a	VRBIS 2019-2023 (Death Certificate)
	Total Population	Total population of San Joaquin County and Priority Neighborhoods	2022: ACS 5-year Estimates Data Profiles
	Age Group	Total population of San Joaquin County and Priority Neighborhoods by age group	2022: ACS 5-year Estimates Data Profiles
	Gender	Total population of San Joaquin County and Priority Neighborhoods by gender	2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
Economics	Children (ages 0-17 years) Living in Poverty	Percent of children 0-17 that live in households with incomes below the federal poverty level	US Census, 2022: ACS 5-year Estimates Data Profiles
	Employed (16+)	Percentage of the population ages 16 years and over who are employed	US Census, 2022: ACS 5-year Estimates Data Profiles
	High Speed Internet	Percent of population with access to high-speed internet	US Census, 2022: ACS 5-year Estimates Data Profiles
	Income Inequality - Gini Index	Ranges from 0, indicating perfect equality (where everyone receives an equal share), to 1, perfect inequality (where only one recipient or group of recipients receives all the income).	KP 2025 Community Health Needs Dashboard
	Jobs Proximity Index	The accessibility and distance to all job locations within its area, with larger employment centers weighted more heavily.	Community Health Needs Dashboard - All Counties in KP States, HUD Policy Development and Research, 2014
	Living in Poverty (<100 Federal Poverty Level)	Percent of population living below the poverty level in the past 12 months	US Census, 2022: ACS 5-year Estimates Data Profiles
	Income	Median household income	US Census, 2022: ACS 5-year Estimates Data Profiles
	Seniors (ages 65+ years) living in poverty	Percent of population ages 65 and older who are living in poverty	US Census, 2022: ACS 5-year Estimates Data Profiles
	Young People Not in School and Not Working	Percent of 16-19-year-olds who are not currently enrolled in school or employed	US Census, 2022: ACS 5-year Estimates Data Profiles
Education	Adults (ages 25+ years) with Some College Education	Percent of the population over age 25 with some college education	2022: ACS 5-year Estimates Data Profiles (State/County/Priority Neighborhoods) 2022: ACS 1-year Estimates Data Profiles (Race/Ethnicity)

Health Topic	Measure	Definition	Data Source, Year
	Adults (ages 25+ years) with No High School Diploma	Percent of the population over age 25 with less than a high school degree	2022: ACS 5-year Estimates Data Profiles
	Bachelors' Education or Higher	Percentage of population over age 25 with a bachelors' education or higher	2022: ACS 5-year Estimates Data Profiles
	High School Enrollment	Percentage of 15-17-year-olds enrolled in school	2022: ACS 5-year Estimates Data Profiles
	On-time high school graduation	Four-Year Adjusted Cohort Graduation Rate, 2019-2020	California Dept of Education, Four-Year Cohort Graduation Rates & Outcomes, 2022-2023
	Preschool Enrollment	Percent of 3 and 4-year-olds enrolled in preschool	2022: ACS 5-year Estimates Data Profiles
	Students proficient in Math	Students Meeting or Exceeding Grade-Level Standard in Mathematics (CAASPP), by Race/Ethnicity, 2022-23. NOTE: The dashboard view will show values for both Reading and Mathematics. See special filters for additional notes	California Assessment of Student Performance and Progress (CAASPP)
	Students proficient in Reading	Students Meeting or Exceeding Grade-Level Standard in Reading (CAASPP), by Race/Ethnicity, 2022-23. NOTE: The dashboard view will show values for both Reading and Mathematics. See special filters for additional notes	California Assessment of Student Performance and Progress (CAASPP)
Food security	Convenience Stores per 1,000 population	Number of Convenience stores per 1,000 population	Community Health Needs Dashboard - All Counties in KP States, USDA Food Environment Atlas, 2016
	Food insecure	Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods.	KP 2025 Community Health Needs Dashboard

Health Topic	Measure	Definition	Data Source, Year
	Grocery Stores per 1,000 population	Number of Grocery stores per 1,000 population	Community Health Needs Dashboard - All Counties in KP States, USDA Food Environment Atlas, 2020
	Low access to grocery store	Percent of individuals with low grocery store access; If a census tract is urban, the percentage of the population that resides more than 0.5 mile from a supermarket. If the census tract is rural, the percentage of the population that resides more than 10 miles from a supermarket. The county total represents the percentage of the population that resides more than .05 mile from a supermarket.	USDA Food Access research Atlas 2019
	SNAP enrollment	Percent of households receiving food stamps/SNAP	US Census, 2022: ACS 5-year Estimates Data Profiles
	Free and Reduced Price Meals	Free and Reduced Price Meals, 2023-24	California Dept of Education, Free and Reduced Price Meals, 2023-24
HEAL opportunities	Exercise opportunities	Percentage of population with adequate access to locations for physical activity	County Health Rankings & Roadmaps, 2024 Data from 2023, 2022 & 2020
	Obesity (ages 18+ years)	Topic: Body Mass Index - 4 level (adult only)	askCHIS, 2018-2022 (pooled)
	Overweight/ Obesity (grades 5,7,9)	Percentage of public-school students in grades 5, 7, and 9 with body composition above the "Healthy Fitness Zone" of the FitnessGram assessment, race/ethnicity and grade level	California Dept of Education, Physical Fitness Test, 2018-2019
	Physical inactivity (ages 18+ years)	Percentage of adults aged 20 and over reporting no leisure-time physical activity.	County Health Rankings & Roadmaps, 2024 BRFSS, 2021

Health Topic	Measure	Definition	Data Source, Year
	Park Access	Percent of residents that live further than a half mile from a park.	Parks for All Californians Park Access Tool, 2020
	Walkability Index	Index scores walkability upon characteristics of the built environment that influence the likelihood of walking being used as a mode of travel	KP 2025 Community Health Needs Dashboard
	Student Participation in California Physical Fitness Test (grades 5, 7, and 9)	Percentage of public school students in grades 5, 7, and 9 participating in the California Physical Fitness Test. There are 5 components to the California Physical Fitness Test: Component 1: Aerobic Capacity, Component 2: Abdominal Strength and Endurance, Component 3: Trunk Extensor and Strength and Flexibility, Component 4: Upper Body Strength and Endurance, and Component 5: Flexibility.	California Department of Education School Accountability Report Card, 2022-23 Reporting year 2024
Housing	Homeownership rate	Percentage of occupied housing units occupied by property owners	US Census, 2022: ACS 5-year Estimates Data Profiles
	Housing Affordability Index	Index of ability of typical resident to purchase an existing home in the area	KP 2025 Community Health Needs Dashboard
	Housing Habitability	Percent of households with kitchen facilities and plumbing.	Comprehensive Housing Affordability Strategy (CHAS) Tables 15A, 15B, 15C, 2016-2020
	Low Income Homeowner (Severe housing cost burden)	Percent of low income owner households with housing costs exceeding 50% of income.	Comprehensive Housing Affordability Strategy (CHAS) Table 8, 2016-2020
	Low Income Renters (Severe housing cost burden)	Percent of low income renter households with housing costs exceeding 50% of income.	Comprehensive Housing Affordability Strategy (CHAS) Table 8, 2016-2020
	Median Rental Cost	Rent per month	KP 2025 Community Health Needs Dashboard

Health Topic	Measure	Definition	Data Source, Year
	Percent of Income for Mortgage	Part of median household income dedicated to monthly payments on a home priced at the median value	KP 2025 Community Health Needs Dashboard
	Severe Housing Cost Burden	Percentage of households with housing costs greater than 50% of income	KP 2025 Community Health Needs Dashboard
	Uncrowded Housing	Percentage of households with less than or equal to 1 occupant per room	US Census, 2022: ACS 5-year Estimates Data Profiles
Mental health	Mental health providers per 100,000 population	Number of Mental health providers per 100,000 population	KP 2025 Community Health Needs Dashboard
	Deaths of despair (age adjusted rate per 100,000)	((VRBIS Deaths of Despair/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023
	Poor mental health (days per month)	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	County Health Rankings & Roadmaps, 2024 Behavioral Risk Factor Surveillance System (BRFSS), 2021
	Suicide deaths (age adjusted rate per 100,000)	((VRBIS Suicide Deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))*(2019 ACS 5 year population estimate - US) calculated per age group, summed, divided by total standard population	VRBIS 2019-2023
Other	Social Vulnerability Index (SVI)	The SVI groups sixteen factors into four themes that summarize the extent to which the area is socially vulnerable to natural or human-caused disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.	SVI Interactive Map | Place and Health - Geospatial Research, Analysis, and Services Program (GRASP) | ATSDR, 2022

Health Topic	Measure	Definition	Data Source, Year
Sexual health	Teen birth rate	Teens giving birth between the ages 15 to 19.	VRBIS 2018-2022 (Birth Certificate) & 2022: ACS 5-year Estimates Data Profiles
	Total birth rate (per 1000)	Total live births (for a specific area and timer period) divided by total population (for the same area and time) multiplied by 1,000.	VRBIS 2019-2023 (Birth Certificate) & 2022: ACS 5-year Estimates Data Profiles
	Chlamydia Rate (per 100,000)	((CalREDIE Clamydia Cases/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CalREDIE, 2019-2023
	Syphilis Rate (per 100,000)	((CalREDIE Syphilis Cases/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CalREDIE, 2019-2023
	Gonorrhea Rate (per 100,000)	((CalREDIE Gonorrhea Cases/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CalREDIE, 2019-2023
	HIV deaths (per 100,000)	(deaths/5)/(2019 ACS 5 year population estimate -San Joaquin County))	CDPH HIV data, 2018-2022 (SJC HIV/AIDS DUA file, 2023Q4)
	HIV prevalence in pop over 13 (per 100,000)	(total HIV/AIDS cases)/(2019 ACS 5 year population estimate -San Joaquin County)	CDPH HIV data, 2018-2022 (SJC HIV/AIDS DUA file, Q4 of each year)
Social support	Seniors Living alone (ages 65+ years)	Percent of total households with someone 65 and older living alone	US Census, 2022: ACS 5-year Estimates Data Profiles
	Limited English Proficiency	Percent of the population ages 5 and older that speak a language other than English at home and speak English less than “very well”	US Census, 2022: ACS 5-year Estimates Data Profiles
	Disability Population (ages <65 years)	Population under 65 with a disability	US Census, 2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
	Disability Population (all ages)	Population with a disability	US Census, 2022: ACS 5-year Estimates Data Profiles
	Two Parent Households	Percentage of family households with children under 18 with two parents present	US Census, 2022: ACS 5-year Estimates Data Profiles
Substance use	Alcohol-impaired Driving Deaths	Number of people killed in a crash involving a driver or motorcycle rider with a blood alcohol concentration of .08 grams per deciliter or greater / total fatalities	KP 2025 Community Health Needs Dashboard
	Current Smokers	Adult Smoking is the percentage of the adult population in a county who both report that they currently smoke every day or some days and have smoked at least 100 cigarettes in their lifetime.	County Health Rankings & Roadmaps, 2024 BRFSS, 2021
	Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted), Excessive Drinking measures the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days.	County Health Rankings & Roadmaps, 2024 BRFSS, 2021
	Opioid-Related Overdose Deaths (per 100,000)	Age adjusted rate of opioid-related overdose deaths by race/ethnicity	skylab.cdph , 2022
Transportation	Workers commuting by transit, biking or walking (Active Commuting)	Percent of population 16 and older who commute to work by walking, cycling, or public transit (excluding taxicabs)	US Census, 2022: ACS 5-year Estimates Data Profiles
	Automobile Access	Percentage of households with access to an automobile	US Census, 2022: ACS 5-year Estimates Data Profiles
	Workers Driving Alone to Work	Percent of population 16 and older who drive alone to work in a car, truck, or van	US Census, 2022: ACS 5-year Estimates Data Profiles
	Workers Driving Alone with Long Commutes	Percent of population 16 and older who drive alone to work with a commute of 60 minutes or more	US Census, 2022: ACS 5-year Estimates Data Profiles

Health Topic	Measure	Definition	Data Source, Year
	Retail Density	Gross retail, entertainment, and education employment density (jobs per acre)	U.S EPA Smart Location Database 3.0, 2021

Appendix B: San Joaquin County CHNA Secondary Data Table

Prevalence/incidence rates for indicators of health status, behavior, and risk factors are shown below for San Joaquin County in comparison to statistics for the State of California. Indicators (either percentage of county population or a rate per designated number of residents) are presented across 15 health need categories. Definitions for each indicator and associated data source are provided in Appendix A. Table 1 below notes statistically significant differences for 1) indicators for which the county performs markedly worse than California averages and 2) indicators for which ethnic disparities are present within the county. Ethnic groups examined include Hispanic/Latino, White, Asian, Black/African American, Pacific Islander/Native Hawaiian and American Indian/Alaska Native populations, as well as those who are mixed race or identify with other groups. These differences point to notable health needs across the county and/or for particular ethnic groups, which are discussed in further detail in Section VII.

Table 1: Prevalence/Incidence Rates for Indicators of Health Status, Behavior, and Risk Factors

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
Access to Care	Infant deaths (per 1000 live births)	5.3	4.2	✓	
	Uninsured children (ages <19 yrs)	2.6%	3.4%		✓
	Insured (ages 19-64 yrs)	90.5%	90.0%		✓
	Medicaid/public insurance enrollment	42.5%	38.5%		
	Low birth weight	7.7%	7.4%	✓	✓
	Pre-term births	9.3%	9.1%	✓	✓
	Prenatal care in 1st trimester	79.1%	86.3%	✓	✓
	Dentists per 100,000 population	58.9	91	✓	
	Primary care physicians per 100,000 population	58.0	81.6	✓	
Cancer	Cancer deaths (all sites combined)	138.9	122.0	✓	✓
	Breast cancer deaths	20.1	17.6	✓	

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	Colorectal cancer deaths	13.7	11.5	✓	✓
	Lung cancer deaths	25.0	20.6	✓	✓
	Prostate cancer deaths	20.8	18.2	✓	✓
	Breast cancer incidence	113.9	124.1		✓
	Colorectal cancer incidence	36.7	33.5	✓	✓
	Lung cancer incidence	40.9	36.8	✓	✓
	Prostate cancer incidence	90.2	99.0		✓
	Cancer incidence (all sites combined)	397.1	398.3		
Chronic Disease	Poor physical health (days per month)	3.7	3.1	✓	
	Poor or fair health (ages 18+ yrs)	22.2%	17.2%	✓	✓
	Heart disease prevalence (ages 18+ yrs)	7.7%	6.9%		
	Heart disease hospitalizations	33.1	31.2		✓
	Heart disease deaths	148.9	142.2	✓	
	Stroke prevalence	3.1%	2.6%		
	Stroke hospitalizations	9.6	10.4		✓
	Stroke deaths	49.2	39.1	✓	
	Diabetes prevalence (ages 18+ years)	14.9%	10.5%	✓	✓
	Asthma ED visits (all ages)	57.9	42.6		✓
	Asthma Hospitalizations (all ages)	5.0	4.5		✓
	Asthma ED visits (ages 0-17 years)	76.0	63.4		
	Asthma Hospitalizations (ages 0-17 years)	9.5	8.3		
	Asthma prevalence (all ages)	18.4%	15.4%	✓	✓
	Asthma prevalence (ages 0-17 yrs)	23.7%	12.5%	✓	✓

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
Climate and Environment	Urban Tree canopy cover	1.4	4.0		
	Road network density	18.3	20.6		
	Coastal flooding risk	0.0	5.5		
	Drought risk	99.7	2.5	✓	
	Heat wave risk	95.6	8.4	✓	
	Air pollution: PM2.5 concentration	10.54	10.18		
	River flooding risk	57.7	29.3	✓	
	Water Contaminants	661.27	477.98	✓	
Community Safety	Injury deaths	68.9	54.9	✓	
	Motor vehicle crash deaths	16.8	10.8	✓	
	Pedestrian accident deaths	1.5	1.6		
	Violent crimes	681.3	488.2	✓	
	Premature death (YPLL)	8327	6373	✓	
Economics	Income	$82,837	$91,905	✓	✓
	Employed (16+ years old)	56.8%	59.3%	✓	✓
	Jobs Proximity Index	43.5	47.7		
	Income inequality – Gini Index	0.4	0.4		
	Living in poverty (<100% Fed Poverty Level)	12.9%	12.1%	✓	✓
	Seniors (ages 65+ years) living in poverty	11.3%	11.0%		✓
	Children living in poverty	17.4%	15.6%		✓
	Young people not in school and not working	9.3%	6.6%	✓	
	High speed internet	89.6%	91.5%	✓	✓
Education	Preschool enrollment	38.2%	44.7%	✓	

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	High school enrollment	96.7%	97.3%		
	Students proficient in math	27.1%	34.6%	✓	✓
	Students proficient in reading	39.5%	46.7%	✓	✓
	On-time high school graduation	82.3%	86.2%	✓	✓
	Adults with no high school diploma	19.8%	15.6%	✓	✓
	Adults with some college education	22.2%	20.2%		✓
	Bachelor's education or higher	20.3%	35.9%	✓	✓
Food Security	SNAP enrollment	15.3%	10.3%	✓	✓
	Convenience stores per 1,000 population	0.2	0.2		
	Grocery stores per 1,000 population	0.2	0.2		
	Low access to grocery store	28.4%	32.4%		
	Food insecure	10.8%	9.8%		
	Free and reduced-price lunch	66.1%	61.7%	✓	
HEAL Opportunities	Obesity (ages 18+ years)	35.5%	28.1%	✓	✓
	Overweight/obesity (grades 5,7,9)	43.3%	39.7%	✓	✓
	Physical inactivity (ages 18+ years)	24.9%	19.9%	✓	
	Exercise opportunities	89.0%	94.0%	✓	
	Walkability Index	10.3	12.1	✓	
	Park access	27.0	21.0		
Housing	Homeownership	60.0%	55.6%		✓
	Uncrowded housing	91.5%	91.8%		✓
	Low income renters (Severe housing cost burden)	23.7%	25.5%		
	Low income Homeowner (Severe housing cost burden)	11.9%	12.7%		

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	Severe housing cost burden	16.9%	19%		
	Median rental cost	$1,527	$1,831		
	Housing Habitability	98.8%	98.7%		
	Housing affordability index	82	72.7		
	Percent of income for mortgage	29.7%	38.3%		
Mental Health	Mental health providers per 100,000 population	273.7	425.5	✓	
	Deaths of despair per 100,000 population	63.5	56.4	✓	✓
	Suicide deaths	10.8	10.5		✓
	Poor mental health (days per month)	4.7	4.7	✓	
Sexual Health	HIV deaths	4.3	5.2		✓
	Total birth rate	12.5	11.2	✓	
	Teen birth rate	14.9	11.1		✓
	Gonorrhea rate	198.6	204.7		✓
	Chlamydia rate	542.8	535.8	✓	✓
	Syphilis rate	62.9	39.7	✓	✓
	HIV prevalence (ages 13+ years)	190.6	354.3		✓
Social Support	Disability Population (all ages)	12.2%	11.0%		
	Disability Population (ages <65 years)	8.3%	7.1%		✓
	Limited English proficiency	41.1%	39.0%	✓	✓
	Seniors living alone (ages 65+ years)	20.9%	22.0%		
	Two parent households	77.4%	77.6%		
Substance Use	Current smokers	13.1%	8.8%	✓	
	Opioid-related overdose deaths per 100,000 population	14.5	18.7		✓

Category	Indicator	San Joaquin County (Rate or %)	State of California (Rate or %)	SJC Performs Worse than CA	Ethnic Disparity Present
	Alcohol-impaired driving deaths	29.5%	26.6%	✓	
	Excessive drinking	16.5%	17.2%		
Transportation	Workers driving alone to work	82.7%	79.2%	✓	✓
	Workers driving alone with long commutes	19.9%	10.5%	✓	
	Workers commuting by transit, biking or walking (Active Commuting)	3.0%	7.8%	✓	
	Retail density	0.1	n/a	✓	
	Automobile Access	94.8%	93.1%		

Appendix C: Community Input Tracking Form

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
1	Key Informant Interview	Catholic Charities	1	Low income, medically underserved, children, youth and families, seniors, immigrants, veterans, unhoused and at risk for being unhoused	Leader	4/9/24	Administers direct social services and advocacy through a variety of programs for the most vulnerable and underrepresented citizens
2	Key Informant Interview	San Joaquin County Public Health Services	1	Public health	Leader	4/15/24	Responsible for protecting, promoting and improving the health and well-being for all who live, work, and play in San Joaquin County.
3	Key Informant Interview	San Joaquin County Continuum of Care	2	Communities of Color, medically underserved and low income	Leader	4/17/24	Provides information, resources, and leadership on evidence-based methods to end homelessness in San Joaquin County utilizing the “Continuum of Care” model
4	Key Informant Interview	San Joaquin County Behavioral Health Services	1	Communities of Color, medically underserved and low income individuals with mental health and substance use treatment needs	Leader	4/17/24	Provides integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.
5	Key Informant Interview	El Concilio Council for the Spanish Speaking	1	Communities of Color, medically underserved and low income	Leader	4/19/24	Empowers diverse communities to realize their greatest potential through outreach, education, counseling, job training and awareness building of community resources
6	Key Informant Interview	Community Medical Centers, Inc.	1	Communities of Color, medically underserved and low income	Leader	4/23/24	System of 11 federally qualified health centers (FQHCs) providing health services to low income, underinsured and high need populations

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
7	Key Informant Interview	Family Resource and Referral Center	1	Communities of Color, medically underserved and low income families	Leader	4/24/24	Provides child care referrals and administers child care and nutritional resources; conducts workshops in effective child rearing, child care, and child safety.
8	Key Informant Interview	San Joaquin County Department of Aging and Community Services	1	Older adults, adults with disabilities, family caregivers, and residents in long-term care facilities	Leader	4/24/24	Helps older adults find employment; supports older and disabled individuals to live as independently as possible; promotes healthy aging and community involvement; and assists family members in their vital care giving role.
9	Key Informant Interview	Central Valley Gender Health and Wellness	2	LGTBQ+ communities including medically underserved, low income, communities of color, unhoused	Leader	5/16/24	Serves the diverse LGBTQ+ community in San Joaquin County by championing equity and well-being for all through a safe and supportive community hub providing access to healthcare, mental health support, educational resources, and housing and legal assistance
10	Key Informant Interview	First 5 of San Joaquin	1	Communities of Color, medically underserved and low income children ages 0-5 and their families	Leader	5/17/24	Provides financial support for health, preschool and literacy programs, and fosters active participation of parents, caregivers, educators and community members in the lives of young children, prenatal to 5 years
11	Focus Group	OVP – Office of Violence Prevention City of Stockton	10	Youth, Communities of Color, medically-underserved, low income, impacted by gang violence	Member	9/11/24	Works with community partners to reduce gun violence and gang violence in Stockton; provides services to individuals impacted by gun and gang violence.
12	Focus Group	OVP – Office of Violence Prevention City of Stockton	10	Youth, Parents/guardians of youth, Communities of Color, medically-underserved, low income	Member	9/13/24	Works with community partners to reduce gun violence and gang violence in Stockton; provides services to individuals impacted by gun and gang violence.
13	Focus Group	El Concilio Council for the Spanish Speaking	10	Communities of Color, older adults	Member	9/16/24	Empowers diverse communities to realize their greatest potential through outreach, education, counseling, job training and awareness building of community resources

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
14	Focus Group	L.O.V.E.U Foundation	10	Communities of Color, parents, low income	Member	9/20/24	Community church serving youth and families of color
15	Focus Group	Public Health Advocates	8	Youth, BIPOC, low income	Member	9/24/24	Program for low income youth of color learning about public health policy and redlining to create neighborhood change
16	Focus Group (virtual)	San Joaquin County Public Health Services Perinatal Equity Initiative & Black Infant Health Community Advisory Board	7	Communities of color, medically-underserved	Member	9/25/24	Advocates for improved Black/African American birth outcomes. Represents birth workers, hospitals and clinics, and community organizations.
17	Focus Group	L.O.V.E.U Foundation	8	Communities of color, low income	Member	9/27/24	Community church serving youth and families of color
18	Focus Group	OVP – Office of Violence Prevention City of Stockton	10	Youth, Communities of color, low income, victims of gun violence	Member	9/27/24	Works with community partners to reduce gun violence and gang violence in Stockton; provides services to individuals impacted by gun and gang violence.
19	Focus Group	Public Health Advocates	9	Youth, BIPOC, low income	Member	9/28/24	Program for low income youth of color learning about public health policy and social injustices to create neighborhood change
20	Focus Group	El Concilio Council for the Spanish Speaking	10	Communities of color, undocumented immigrants, Hispanic/Latino population, Spanish-speaking, Indigenous population, medically underserved, low income	Member	9/30/24	Empowers diverse communities to realize their greatest potential through outreach, education, counseling, job training and awareness building of community resources

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
21	Focus Group	L.O.V.E.U Foundation	7	Communities of color, low income	Member	10/6/24	Community church serving youth and families of color
22	Focus Group	Mayfair Christian Church	10	Older adults	Member	10/6/24	Christian church serving the Stockton community.
23	Focus Group	Asian Pacific Self-Development and Residential Association	10	Older adults, Cambodian population, Khmer and Lao-speaking, refugees, chronic physical/mental health conditions, medically-underserved, low income	Member	10/8/24	Provides housing and economic support to Khmer refugees who experienced trauma and economic hardship after fleeing the Khmer Rouge.
24	Focus Group	Community Health Leadership Council	10	Communities of Color, Hispanic/Latino population, Spanish-speaking, parents of young children, chronic physical/mental health conditions, low income, medically-underserved	Member	10/9/24	Works with community partners across healthcare, education, and business to identify and address pressing public health issues in San Joaquin County.
25	Focus Group	Community Health Leadership Council	10	Communities of Color, Hispanic/Latino population, Spanish-speaking, chronic physical/mental health conditions, low income, medically-underserved, migrant workers	Member	10/9/24	Works with community partners across healthcare, education, and business to identify and address pressing public health issues in San Joaquin County.
26	Focus Group	Emergency Food Bank of Stockton	10	Older adults, low income, chronic health conditions	Member	10/12/24	Provides nutrition education and distributes food to low income diabetic and pre-diabetic older adult individuals.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
27	Focus Group	Center for Business and Policy Research (CBPR), University of the Pacific	6	Communities of Color, low income, chronic health conditions	Member	10/15/24	Researches public policy issues facing North San Joaquin Valley region.
28	Focus Group (virtual)	Tracy Area Alumnae Chapter of Delta Sigma Theta Sorority Inc.	8	Youth, Communities of Color, Black/African American population	Member	10/16/24	Offers programs in the areas of educational development, economic development, international awareness and involvement, physical and mental health, and political awareness and involvement for members.
29	Focus Group	Housing Authority of San Joaquin	16	Communities of Color, Hispanic/Latino population, Spanish-speaking, low income	Member	10/16/24	Provides affordable housing to older adults, low income individuals, working families, and disabled residents of San Joquin County.
30	Focus Group	Tracy Area Alumnae Chapter of Delta Sigma Theta Sorority Inc.	8	Communities of Color, Black/African American population	Member	10/16/24	Offers programs in the areas of educational development, economic development, international awareness and involvement, physical and mental health, and political awareness and involvement for members.
31	Focus Group	Health Plan of San Joaquin	7	Communities of Color, chronic health conditions	Member	10/17/24	Provides community-led health services to Medi-Cal recipients.
32	Focus Group	Health Plan of San Joaquin	9	Communities of Color, chronic health conditions, low income, medically-underserved, community care providers	Member	10/17/24	Provides community-led health services to Medi-Cal recipients.
33	Focus Group (virtual)	Public Health Advocates	4	Older adults, low income, community leaders in climate and health	Member	10/17/24	Develops community-led solutions to climate change.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
34	Focus Group	San Joaquin County Public Health Services Staff Cohort	13	Staff of Public Health Services	Leader	10/17/24	Protects, promotes, and improves health and the conditions that impact wellbeing for all in San Joaquin County.
35	Focus Group	Reinvent South Stockton Coalition	10	Youth, low income	Member	10/19/24	Advocates for improvements to public health, education, and housing in South Stockon.
36	Focus Group	Amelia Ann Adams Whole Life Center	8	Communities of color, low income, impacted by the Justice System	Member	10/22/24	Serves at-risk, under resourced individuals and focuses on neighborhood change to build thriving communities.
37	Focus Group	Reinvent South Stockton Coalition	8	Communities of Color, Hispanic/Latino population, Spanish-speaking, medically-underserved, low income	Member	10/23/24	Advocates for improvements to public health, education, and housing in South Stockon.
38	Focus Group (virtual)	San Joquin Opioid Safety Coalition	7	Communities of Color	Member	10/23/24	Opioid safety stakeholders working to reduce opioid overdoses and deaths in their communities.
39	Focus Group	Emergency Food Bank Stockton	8	Communities of Color, Hispanic/Latino population, Spanish-speaking, chronic health conditions, low income, medically underserved	Member	10/25/24	Provides nutrition education and distributes food to low income diabetic and pre-diabetic adult individuals.
40	Focus Group	Stanislaus State Stockton Campus	10	Young adults, Communities of Color, low income	Member	10/28/24	Local state college serving community of color and low income populations.
41	Focus Group	Housing Authority of San Joaquin	11	Older adults, low income	Member	10/28/24	Provides affordable housing to older adults, low income individuals, working families, and disabled residents of San Joquin County.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
42	Focus Group	Central Valley Gender Health and Wellness	8	LGBTQ+ community, chronic physical/mental health conditions, medically underserved, low income	Member	10/29/24	Serves the diverse LGBTQ+ community in San Joaquin County by championing equity and well-being for all through a safe and supportive community hub providing access to healthcare, mental health support, educational resources, and housing and legal assistance
43	Focus Group	Dignity Health, St. Joseph's Behavioral Health	7	Behavioral healthcare workers	Member	10/29/24	Provides behavioral health services such as behavioral evaluations, chemical recovery program, inpatient services, and outpatient services, to San Joaquin County community.
44	Focus Group	San Joaquin Health Center	4	Unhoused community, Communities of Color, low income, medically underserved, chronic physical/mental health conditions	Member	10/29/24	Provides mobile health care services to unhoused community.
45	Focus Group	St. Joseph's Medical Center, Doctor Up Your Meals Diabetes Health Group	10	Older adults, chronic physical/mental health conditions, medically underserved	Member	10/30/24	Diabetes health and nutrition education program serving adults over 60 who are medically underserved and diagnosed with diabetes or prediabetes.
46	Focus Group	St. Joseph's Medical Center, Cancer Center	2	Older adults, chronic physical/mental health conditions	Member	10/30/24	Medical facility cancer treatment center serving San Joaquin County.
47	Focus Group	San Joaquin Health Center	6	Unhoused community, Communities of Color, low income, medically underserved, chronic physical/mental health conditions	Member	10/30/24	Provides mobile health care services to unhoused community.
48	Focus Group	Healings in Motion	10	Communities of color, chronic physical/mental health conditions, low income, medically underserved	Member	11/1/24	Organization assists survivors of stroke, traumatic brain injuries, and neurological impairments, and provides support and resources for caregiver.

#	Data Collection Method	Organization	#	Perspective Represented	Role in Target Group	Date Input Gathered	Rationale
49	Focus Group	Little Manila Rising	6	Communities of Color, medically underserved, low income	Member	11/5/24	Serves the South Stockton Filipino community, addressing issues of marginalization through educational, environmental, and public health programs.
50	Focus Group	St. Joseph's Medical Center, Power Hour Diabetes Health Group	10	Communities of Color, chronic physical/mental health conditions	Member	11/6/24	Diabetes health and nutrition education program serving adults who are diagnosed with diabetes or prediabetes.
51	Meeting	Resilient Community Advisory Committee	39	Disenfranchised communities most affected by COVID-19	Member	11/14/24	Brings together those who serve, and have trusting relationships with, the most disenfranchised communities in SJC to engage community partners and residents in the development of messages tailored to resonate with community members, promote community outreach and disease mitigation activities, and gather feedback and guidance on planned activities.
52	Meeting	SJC CHNA Steering Committee	33	Chronic physical/mental health conditions, Communities of Color, medically underserved, and low income	Leader	1/21/25	CBOs/public agencies/health care organizations that work with low income and ethnic populations in SJC work to address health disparities and are a critical voice in determining priority health needs.

CHNA 2025 Key Informant Interview Protocol

INTRODUCTION

Thank you for agreeing to do this interview today. My name is **[NAME]** with **Ad Lucem Consulting**. Kaiser Permanente has partnered with **Ad Lucem Consulting** to conduct the Community Health Needs Assessment, or CHNA, in STANISLAUS COUNTY**.** For your background, we do not play any role in Kaiser Permanente's grant-making.

The CHNA, which is conducted every three years, includes consideration of health outcomes and social and environmental health factors, along with community perspectives, in order to identify key health-related issues and assets in each community Kaiser Permanente serves. This information informs how Kaiser Permanente develops strategies to address selected community health needs. You are an important contributor to this assessment because of your knowledge of the community you serve or represent. We greatly value your input.

CONSENT SCRIPT: By participating in this interview, you agree that Kaiser Permanente (KP) will use the information you provide - including de-identified statements or quotes - in the community health needs assessment. Information will be compiled and reported in a way that is not attributable to you. Additionally, because KP collaborates with hospital partners as part of its community health needs assessment process, you agree that KP may share transcripts or notes from this interview with partner organizations. Do you have any questions before we get started?"

If they continue with the interview, we accept that as passive assent.

- Do we have your permission to record the interview?

➔ **If yes, start the recording. If no permission granted, take verbatim notes.**

HEALTH NEEDS

Great – let's get started!
For individuals/organizations interviewed last cycle: I see that you (or your organization) participated in an interview for the previous CHNA – thank you for your participation last cycle. The questions this time are quite similar, and we are interested to hear how things may or may not have changed.

First, I would like to ask a few questions about health needs and potential strategies to address them in your community. This will be followed by questions about inequities that have an impact on these health needs.

3. What are the 2-3 healthiest assets or characteristics of **San Joaquin County** (e.g., a strong transportation system, an active arts and culture sector, safe and accessible spaces for physical activity, community resilience)?

   a. What are the facilitators in the community that support these healthy characteristics? (e.g., local elected official support, funding, policies, strong community organizations)?

4. What are the 3 biggest health issues and/or conditions your community struggles with? Please briefly describe the issues. [*If unsure what we mean: e.g., a health issue can be a factor that contributes to poor health, like lack of stable housing, or a health outcome like heart disease or cancer.]*

   a. What are the factors that create these health issues and why are they the top needs? *A need can be a top priority because it impacts lots of people in the County, impacts vulnerable populations such as kids or older adults, costs the County lots of money, or impacts County residents' ability to have a high quality of life. Factors that create priority issues can include economics, societal/social factors, environmental factors.*
   b. How have you seen community needs change over the last few years in **San Joaquin County**?
   c. How has COVID pandemic recovery, including expiration of certain benefits, influenced the magnitude of these needs in **San Joaquin County**?

5. You indicated that **[RESTATE THE top 3 health needs mentioned above**] are significant health needs in your community. What are one or two of the biggest challenges to addressing each of these needs in **San Joaquin County?**

6. *If the interviewee did not mention any of the following (list health needs addressed in 2022 Report* Are these health needs still a priority? If no, what changed?

EQUITY

Now I have a few questions to ask you about inequities in **San Joaquin County** that have an impact on the important health needs you mentioned. This could be racial inequity as well as inequities related to gender, age, geography, and other factors. Inequities can also relate to access to services, for instance when lack of culturally and

language appropriate services are not available and prevent community residents from receiving needed services.

REQUIRED: For each question in the equity section, probe for more detail about groups or subgroups:

1. *American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/other Pacific Islander, or Individuals of Hispanic/Latino origin (i.e., if a participant mentions the Asian population, who do they mean specifically? If they bring up Latinx, what ethnicities are they referring to?)*
2. *Socially disadvantaged groups (i.e., if the participant says general terms like "marginalized", "disadvantaged", "underrepresented" or others, who are they referring to in their geographic context?*
3. *If the participant says all subgroups or declines to specify that is ok, just looking for more detail when it's relevant.*

7. Are there certain people or geographic areas in **San Joaquin County** that have been affected by the issues we've been talking about more than others? If so, in what ways? Is this relevant to all the needs we've been talking about or a specific one?
   a. Which specific groups of the population, if any, should Kaiser Permanente focus on to reduce disparities and inequities related to race or other factors?

8. What are effective strategies to reduce health disparities and address structural inequities in **San Joaquin County**?

   a. Is there existing work underway that is promising?
   b. Who are the individuals or organizations in **San Joaquin County** that are important for connecting the groups most affected by disparities to community resources that address [list *most important health need(s)*]?

COMMUNITY RESOURCES and POTENTIAL INVESTMENTS

Finally, I would like to ask about the resources available to address important health needs in the community. This will be followed by a question about potential future investments.

9. What are the key community resources, assets, or partnerships in **San Joaquin County** that can help address the significant health needs we talked about today?

   a. What services does [*your organization*] provide to help meet those needs in **San Joaquin County**?

b. Describe how other organizations or collective efforts, if any, are working to address these needs in **San Joaquin County**?

10. Are there any significant gaps in community resources, assets, or partnerships in **San Joaquin County** to address the significant health needs we talked about today?

a. Who is not yet involved in **San Joaquin County** but needs to be to help address the top health needs we talked about? *Repeat top health needs if needed.*

11. How would you like to see health care organizations in **San Joaquin County** invest in community health programs or strategies to address these needs**?** What would those investments be?

CLOSING

12. Are there any other **thoughts or comments you would like to share that we have not discussed?**

Appendix E: Focus Group Screener and Guide

Focus Group Screener Questions

Thank you for joining our focus group. To learn more about you, we'd like you to fill this survey out. All information is confidential and will be used only for our research.

1. How long have you lived in San Joaquin County? _____ Number of years

2. Race/Ethnicity (check all that apply):

- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Hispanic/Latino
- ☐ White/ Caucasian
- ☐ Different race/ethnicity (please describe):

3. How old are you? _____ Number of years

4. Gender? _____

Thank you!

Grupo de Enfoque Encuesta

Gracias por unirse a nuestro grupo de discusión. Para aprender más sobre usted, nos gustaría que complete esta encuesta. Toda la información es confidencial y se usará sólo para nuestra investigación.

1. **¿Por cuánto tiempo ha vivido usted en el Condado de San Joaquin?**

   _____ Número de años

2. **Raza/grupo étnico** (favor de marcar todo lo que aplique a usted):
   - ☐ Negro/Afro Americano
   - ☐ Indio Americano o nativo de Alaska
   - ☐ Asiático
   - ☐ Nativo de Hawaii/Islas del Pacífico
   - ☐ Hispano/Latino
   - ☐ Blanco/Caucásico
   - ☐ Raza/etnicidad diferente (Por favor describa): _____

3. **¿Qué edad tiene usted?** _____ Número de años

4. **¿Género?** _____

¡Gracias!

Focus Group Guide

Welcome

- Hello everyone, thank you for joining our discussion today.
- My name is (moderator).
- This is (note taker) who will be taking notes during our conversation.
- Our discussion today will take about 1 hour.
- Your participation is voluntary, and you can leave the group at any time, without explanation.

Purpose of Focus Group

Community organizations across the County are conducting focus groups to learn more about what residents feel are our most important health issues. We want to know what you, as a community member, think about what makes it easy or difficult to be healthy and what services and resources are available or needed in your community to improve health. Your opinions will help our county nonprofit hospitals, Public Health Services, community based organizations, insurers and others create a three year plan to work on the major health issues affecting people in the County.

Verbal Consent

By continuing to participate in this focus group, you are indicating your consent to have the information you provide used for the San Joaquin County Community Needs Health Assessment. The information collected during the focus group may be shared with other hospitals in San Joaquin County. Information shared from the focus group will not include your name or identifying information. If you do not consent, please leave the focus group.

Meeting Agreements

There are no right or wrong answers because we're interested in everyone's thoughts and opinions and people often have different opinions.

Please, feel free to share your opinions even though it's not what others have said. If there are topics you don't know about or a question you are not comfortable answering, feel free to not answer. All input will be welcomed and valued.

Next, we want to have a group discussion, but we'd like only one person to talk at a time because we want to make sure everyone has a chance to share their opinion.

The last guideline is about protecting your privacy. Your name will not be used in any reports, and your name will not be linked to comments you make. I'd also like for all of us to agree that what is said in this group stays with the group. Are there other meeting agreements you would like us to add?

Introductory Question

Let's start by introducing ourselves. Tell us your first name.

Community Health

We would like to discuss what is healthy and not so healthy about your community.

1. **Think about your community right now. What is healthy about your community?**

Things that make a community healthy can include the environment (sidewalks, clean streets, parks), social factors (e.g., feeling safe, access to mental health services), opportunities for healthy behaviors (e.g., places to buy healthy food, places to exercise) community services and events (e.g., low cost or free activities for families), and health care (e.g., access to health care services)

2. **What makes it difficult to be healthy in your community, including any lasting impacts from the COVID pandemic?**

For example, lack of access to health services, few grocery stores with healthy, affordable food, unsafe neighborhoods, lack of access to transportation, lots of pollution in the air, no safe places to be active, no affordable dental care

Identifying top health issues/successful strategies to address health issues

3. **Thinking about what does or does not make your community healthy, what do you think is the one top health issue facing your community?**

A health issue can be a disease like heart disease or cancer, or something that causes poor health like unhealthy food or drug abuse, or something that affects overall wellbeing like mental health, violence or access to care. We know you might have ideas about many important health issues, but try to limit your answer to identify the most important health issue.

4. **Thinking about the top health issues you identified, do you think there are certain groups of people that are more affected by these issues than others? For example, racial/ethnic groups, low income groups, specific neighborhoods or areas in San Joaquin County, or other marginalized communities?** *PROMPT:* **Which groups?**

5. **Thinking about the top health issue you identified as most important, what are the top one or two things that could be done to fix this issue?**

Some examples could be improvements to your community (like fixing sidewalks so it is easier to walk or starting farmers markets where you can get fruits and vegetables) or changes to clinic services (like health and mental health services available at places you usually go, services available in your preferred language).

Final Question

6. **We're just about ready to wrap up. Is there anything else you feel is important for us to know about health in your community?**

Thank you for your participation!

Guía Grupos de Discusión

Bienvenida

- Hola a todos y gracias por participar hoy en este grupo de discusión.
- Mi nombre es (moderator).
- El/ella es (Note taker) y se encargará de tomar notas durante nuestra conversación.
- La reunión durará, más o menos una hora.
- La participación es voluntaria y pueden retirarse del grupo cuando quieran, sin tener que dar explicaciones.

Objetivos del grupo de discusión

Organizaciones comunitarias en todo el condado están llevando a cabo grupos de discusión para aprender más sobre lo que los residentes sienten que son nuestros problemas de salud más importantes. Queremos saber lo que usted, como miembro de la comunidad, piensa acerca de lo que hace que sea fácil o difícil estar saludable y qué servicios y recursos hay disponibles o se necesitan en su comunidad para mejorar la salud. Su opinión ayudará a los hospitales sin fines de lucro de nuestro condado, los Servicios de Salud Pública, las aseguradoras y otros a crear juntos un plan de tres años para trabajar en los principales problemas de salud que afectan a las personas en el condado.

Consentimiento Verbal

Al continuar participando en este grupo de discusión, usted está indicando su consentimiento para que la información que proporcione sea utilizada para la Evaluación de las Necesidades de Salud de la Comunidad del Condado de San Joaquín. La información recopilada durante el grupo de discusión puede compartirse con otros hospitales del condado de San Joaquín. La información compartida del grupo de discusión no incluirá su nombre ni otra información que lo identifique. Si no está de acuerdo, por favor abandone el grupo de discusión.

Reglas Básicas

No hay respuestas correctas o incorrectas porque nos interesa conocer las ideas y las opiniones de todos, y las personas, muchas veces, tienen opiniones diferentes.

Por favor, sientan la libertad de decir lo que piensan, aunque no sea lo mismo que dijeron otros.
Si hay temas que no conocen o preguntas con las que no se sienten cómodos, simplemente no las respondan.
Todas las ideas son valiosas y bienvenidas.

Luego, queremos tener una discusión grupal, pero nos gustaría que hable una persona por vez porque queremos estar seguros de que todos tengan la oportunidad de dar su opinión.

La última indicación tiene que ver con la privacidad. Su nombre no va a utilizado en ningún informe y su nombre no se lo va a asociar con los comentarios que hagan aquí. También me gustaría que nos pongamos de acuerdo en que lo que se dice en este grupo, queda en este grupo. ¿Hay alguna otra regla que les gustaría agregar?

Pregunta introductoria

Empecemos por presentarnos. Díganos su nombre.

Salud de la comunidad

Nos gustaría hablar de lo que es saludable y no tan saludable en su comunidad.

1. **Piensen en cómo está la comunidad en este momento. ¿Qué cosas les parecen saludables de su comunidad?**

Cosas que hacen que una comunidad sea saludable puede incluir el entorno (por ejemplo, las aceras, las calles limpias y los parques); los factores sociales (por ejemplo, sentirse seguro, acceso a servicios de salud mental); oportunidades para tener hábitos saludables (por ejemplo, lugares donde comprar alimentos saludables, espacios donde hacer ejercicio); servicios comunitarios y eventos (por ejemplo, actividades de bajo costo o gratis para la familia); y el cuidado médico (por ejemplo, el acceso a los servicios de cuidado médico).

2. **¿Qué dificulta el estar saludable en su comunidad, incluyendo las repercusiones de la pandemia de COVID?**

Por ejemplo: falta de acceso a los servicios de salud, pocos lugares donde encontrar alimentos saludables y económicos, vecindarios poco seguros, falta de acceso al transporte, mucha contaminación en el aire, falta de lugares seguros donde hacer actividad física, falta de cuidado dental accesible.

<u>Identificando los principales problemas de salud/estrategias eficaces para resolverlos</u>

3. **Pensando en las cosas que hacen que la comunidad sea saludable o no, ¿cuál cree que es el principal problema de salud que afecta a su comunidad?**

Un problema de salud puede ser una enfermedad, como una enfermedad del corazón o cáncer; o algo que causa falta de salud, como alimentos no saludables o el abuso de drogas; o algo que afecta el bienestar general, como la salud mental, la violencia o el acceso al cuidado médico. Sabemos que, posiblemente, se les ocurran muchos problemas de salud que son importantes, pero traten de limitar la respuesta al problema de salud que consideran más importante.

4. **Pensando en los principales problemas de salud que identificó, ¿cree que hay ciertos grupos de personas que se ven más afectados por estos problemas que otros? Por ejemplo, ¿grupos raciales/étnicos, grupos de bajos ingresos, vecindarios o áreas específicas en el Condado de San Joaquín u otras comunidades marginadas?** *PISTA*: **¿Qué grupos?**

5. **Pensando en el problema de salud que ha identificado como el más importante, ¿qué es lo que se podría hacer para solucionarlo? Nombre una o dos cosas.**

Algunos ejemplos podrían ser mejoras en su comunidad (como arreglar las calles para que sea más fácil caminar o poner en marcha mercados donde se pueda comprar fruta y verdura) o cambios en los servicios clínicos (como servicios de salud y de salud mental disponibles en los lugares a los que suele ir, servicios disponibles en su idioma preferido).

<u>Ultima Pregunta</u>

6. **Ya casi estamos listos para terminar. ¿Hay alguna otra cosa que crean que es importante que sepamos sobre la salud en su comunidad?**

¡Muchas gracias por participar!

Appendix F: Annotated Bibliography of SJC Reports and Assessments

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
First 5 San Joaquin – 2022-2027 Strategic Plan	First 5 San Joaquin	First 5 San Joaquin Strategic Plan	Describes First 5's five-year strategic plan (2022-2027). Details their assessment of community needs and their plan to provide programming in response to these needs within four goals: quality early learning, child health and development, resilient families, and strong systems.	• First 5 partnered with community organizations to hold 15 focus groups. Participants included parents and caregivers, service providers, recipients of Temporary Assistance for Needy Families (TANF), and members of the business community. First 5 also administered an online survey which received 189 responses from the community. • Priority needs identified: ○ Expand and enhance the availability of childcare programs ○ Enhance the childcare workforce through more professional development and recruiting a more diverse childcare workforce ○ Provide parenting skill support and more information for parents about child development ○ Ensure easily accessible food and nutrition assistance ○ Enhance access to services for children with special needs: developmental screenings, treatment/interventions and parent support for children with behavioral issues ○ Expand prenatal/perinatal care: free birth services, birth centers, and lactation consultants ○ Expand mental health care for children and caregivers ○ Expand dental health services for children • Challenges to accessing services faced by families with young children included: ○ Affordable housing ○ Financial concerns ○ Limited public transportation • Investments and strategies in the plan address: ○ High-quality childcare and preschools ○ Developmental screening and early intervention services ○ Oral health services coordination ○ Mental health supports for children and parents ○ Safe and affordable housing ○ Early literacy • Culturally and linguistically appropriate outreach strategies to publicize county services

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
Little Manila Rising California Equitable Recovery Initiative (CERI): South Stockton Community Needs Assessment	Little Manila Rising	Not available	Details the results of Little Manila Rising's community needs assessment of South Stockton residents conducted August to December of 2023. The survey focused on health equity, including asthma mitigation, COVID-19 recovery, and mental health.	• Little Manila Rising received 57 responses to their community survey ○ Racial demographics of population surveyed ▪ 42% Asian ▪ 35% African American/Black ▪ 26% Hispanic/Latinx • More than half of respondents had trouble paying for basic necessities; food, utilities, and debt were sources of financial hardship. • Behavioral and mental health issues such as substance use and lack of information about mental health services were identified as areas of concern. Youth behavioral health services were identified as a need. • Concern expressed about Long COVID and co-infection with asthma • Hesitancy to interact with healthcare providers and financial concerns were identified as barriers to accessing health services • Green space, opportunities for physical activity, and grief support were recommended to support pandemic recovery in the community. • Recommended changes to improve public safety/health in South Stockton: ○ Road and driving infrastructure improvements, such as speed bumps, traffic lights, sidewalks, and lighting ○ Support for children traveling to school alone ○ Increased food access and grocery stores in South Stockton ○ Access to elder care centers ○ Prescription medicine financial assistance ○ Enhanced resources for pet care, and care for abandoned/neglected pets • Recommended community improvements: ○ Programs for financial, economic, and civic literacy ○ More community centers in neighborhoods ○ More green space ○ Minimize/eliminate the warehouses built by tech investors in South Stockton, which negatively impact neighborhood quality of life ○ Improve local news coverage • Policy directions based on findings: ○ Support investments addressing food insecurity ○ Invest in infrastructure to make utilities more affordable and reliable ○ Sustain and deploy funds from the Mental Health Services Act and other community based efforts to address mental health ○ Provide health education on Long COVID ○ Ensure health services staff receive cultural competency and trauma-informed practices training

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
				• Increase funding for community based organizations that provide holistic support services
California Jobs First Part One Baseline Regional Assessment Report North San Joaquin Valley	North Valley Thrive	North Valley Thrive	This document presents North Valley Thrive's research on the public health and economic conditions of the North San Joaquin Valley region. This research will support the planning phase of their partnership with the California Economic Resiliency Fund (CERF) to develop a roadmap to inclusive economic prosperity for the region.	• To develop this report, researchers utilized CalEnviroScreen 4.0, Healthy Places Index, and County Health Rankings. Based on this data, researchers developed five public health "themes" and integrated public health indicators from each data source to evaluate public health conditions in the North San Joaquin Valley Region and compare them to other CERF (Community Economic Resilience Fund) regions • Behavioral and Mental Health, Including Substance Abuse ○ Shortage of mental health providers in North San Joaquin Valley (NSJV) indicates a regional inequity and worsens related inequities such as rates of substance abuse, suicide, and mental illness ○ Elevated mental health indicators for the NSJV likely reflect high levels of mental distress and low availability of mental health care in the region • Environmental ○ CalEnviroScreen ranks NSJV in the 71st percentile for environmental health risks; substantial environmental inequities are experienced in the region. ○ Lower air quality has led to large numbers of cases of asthma and Valley Fever. ○ Agricultural and growing manufacturing/transportation/warehousing industries have led to significant air, land and water pollution. ○ Need for investment in environmental cleanup and strategies to mitigate climate change • Health and Safety ○ NSJV ranks 10th out of 13 regions on the Social Vulnerability Index due to weak ability to respond to disease outbreaks and natural or man-made disasters. ○ The life expectancy inequity in NSJV is likely caused by climate impacts, environmental factors, including environmental injustices, disinvestment in the region and related economic inequalities. ○ Limited outdoor space, extreme heat, and violent crimes are barriers to physical activity for NSJV residents, leading to obesity. ○ Need to invest in green spaces in BIPOC neighborhoods • Healthcare Access and Transportation ○ Residents face barriers accessing health services because of lack of transportation and language barriers.

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
				○ Low English proficiency among NSJV residents ○ Low automobile access among NSJV residents • Income, Education, and Employment ○ NSJV has the lowest ranking among the CERF regions for: asthma, cardiovascular disease, low birthweight infants, educational attainment, housing burdened low income households, linguistic isolation, poverty, and unemployment. ○ Concentration of inequities falls along racial lines and disproportionately affects BIPOC communities ○ Lower levels of educational attainment compared to CA contribute to challenges with unemployment, home ownership, and poverty. ○ English proficiency barriers affect educational attainment.
Uniform Data System (UDS) 2023 - Demographics	Community Medical Centers	Not available	This document presents changes in Community Medical Centers' (CMC) patient demographic data for the year 2023.	• Changes in patient demographics ○ Increases in: male patients, female patients, homeless patients, non-English speaking patients ○ Decreases in: migrant patients ○ Increased number of patients across racial categories ○ Increased number of patients at or below the poverty level ○ Decreased number of patients above the poverty level ○ Increased number of patients on Medicaid and Medicare ○ Stockton: patient increases in all zip codes except 95202 and 95203 ○ Lodi: patient increases in all zip codes except 95632 ○ Manteca/Tracy: patient increases in all zip codes except 95336 • Changes in services ○ Increases in patients seen and total visits ○ In person clinic visits increased and virtual visits decreased ○ Increased medical visits, dental visits, behavioral health visits, substance use disorder services, and other health and wellness supportive services ○ Number of patients/number of visits increased for: hypertension, diabetes, overweight/obesity, tuberculosis, abnormal breast findings, eye exams, oral exams, restorative services, childhood lead test screening, rehabilitative services, anxiety disorders, and other mental health disorders ○ Number of patients/number of visits decreased for: novel coronavirus, seasonal flu vaccine, selected immunizations • Quality measures ○ Decrease in occurrences for the following: childhood immunizations, breast cancer screenings, depression screening and follow-up plan,

Document Title	Sponsoring Organization/ Author	Link to report	Overview	Key Findings
				colorectal cancer screenings, IVD, use of Aspirin or antithrombotic therapies, dental sealants, child/adolescent weight assessment and counseling, tobacco assessment, statin therapy, HIV linkage to care ○ Increase in occurrences for the following: Cervical cancer screenings, depression remission at 12 months, HIV screenings, uncontrolled diabetes, adult weight screening and follow-up, hypertension control

Appendix G: Community Resources

The Community Resources are organized by health need and represent a sampling of organizations addressing these health needs. The list is not exhaustive; there are many other organizations in San Joaquin County providing a variety of services and programs to address the health needs.

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Public Agencies											
San Joaquin County and City Parks and Recreation Departments	Parks and Recreation Departments develop and maintain parks/open spaces, operate facilities including aquatic centers, playgrounds, athletic fields, camps, and community centers, and provide programming that supports physical activity, youth development, relaxation and social interaction.		X	X				X			
San Joaquin County Behavioral Health Services	Provides integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment and recovery needs of SJC residents.	X	X			X					
San Joaquin County Council of Governments	Joint-powers authority comprised of San Joaquin County and the cities of Stockton, Lodi, Manteca, Tracy, Ripon, Escalon, and Lathrop. Fosters intergovernmental coordination with local/regional jurisdictions, State and Federal agencies, the private				X	X					X

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
	sector, and community groups. Facilitates and administers regional programs, and advocates for regional/inter-regional strategies. Committees include transit, coordinated transportation and land use, climate, housing and economic security.										
San Joaquin County Human Services Agency	Provides State and federally-mandated public assistance and a variety of social service programs for SJC residents. Programs include: California Work Opportunity and Responsibility to Kids (CalWORKs), Foster Care, CalFresh, General Assistance, Medi-Cal, Adoptions, Child Protective Services, Adult Protective Services, In-Home Supportive Services (IHSS), Refugee Assistance, and the Mary Graham Children's Shelter.	X	X	X		X	X	X		X	
San Joaquin County Public Health Services	In partnership with the community, protects, promotes and improves health and well-being for all who live, work, and play in San Joaquin County. Programs and services include chronic disease prevention, nutrition and physical activity, family health, tobacco control, and environmental health.	X		X			X	X		X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Mental/Behavioral Health/Substance Abuse Recovery											
Aegis Medical Systems, Inc.	Offers outpatient substance abuse treatment including detoxification, methadone maintenance, and methadone detoxification.		X								
Community Medical Centers --Recovery Center	Provides medical and behavioral assessment, case management, sobering and treatment to individuals struggling with mental health and substance use issues.		X		X						
National Alliance on Mental Illness, San Joaquin County	Raises community awareness of mental illness and provides support groups and a HelpLine to persons with mental illness and their families and friends, education and training, and advocacy.		X								
St. Joseph's Behavioral Health Center	Provides behavioral evaluations, mental/behavioral health screening, inpatient and day treatment programs, outpatient services, chemical recovery programs and referrals to community resources.	X	X								
The Wellness Center of San Joaquin County	Peer support program for people with or without a mental health diagnosis run by and for individuals with mental health challenges. Offers support groups, classes, meditation classes, one-on-one peer coaching, and substance abuse recovery groups.		X								

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Housing and Homelessness											
Affordable Housing Programs (e.g., Mercy Housing, Eden Housing, Valle Del Sol, Housing Authority County of San Joaquin, STAND, Visionary Homebuilders, Central Valley Low Income Housing Corp.)	Provide housing for low income residents through subsidized housing and rental assistance, or affordable housing units.				X	X	X			X	
Grace and Mercy, Lodi Area	Offers a safety net to persons in need and the homeless by providing dry goods, refrigerated storage, clothing for job seekers, haircuts, a soup kitchen, and shelter from severe weather.			X		X				X	
Homeless Services (e.g., St. Mary's Dining Room, St. Anne's Place, Women's Center Youth and Family Services, Stockton Shelter for the Homeless, Hope Harbor Shelter, Coalition of Tracy Citizens to Assist the Homeless, Gospel Center Rescue Mission, McHenry House Tracy Family Shelter, Tracy Community Connections Center, Tracy Interfaith Ministries)	Provide meals, health care, clothing, hygiene services, shelter and social services to homeless and working poor individuals and families.	X	X	X	X	X	X			X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
San Joaquin Continuum of Care	Provides information, resources, and leadership on evidence-based methods to end homelessness in San Joaquin County utilizing the "Continuum of Care" program developed by U.S. HUD.		X		X						
Health Care											
Federally Qualified Health Centers (e.g., Community Medical Centers, Inc., San Joaquin Community Clinics, Golden Valley Health Centers)	Outpatient clinics providing health services to low income, underinsured and high need populations.	X	X	X				X			
Hospitals/medical centers (e.g., San Joaquin General, Sutter Tracy Community Hospital, Kaiser Permanente Manteca, Adventist Health Lodi Memorial and Dameron Hospital, Dignity Health St. Joseph's Medical Center)	Multiple facilities dedicated to comprehensive outpatient and inpatient services including primary care and specialty care.	X	X	X							
MediCal Managed Care Plans (MCPs), e.g., Health Plan of San Joaquin, Health Net Community Solutions, Inc., Kaiser Permanente	MCPs work toward a more equitable health system that will result in better health outcomes for Californians by providing high-quality, equitable and comprehensive health insurance coverage.	X	X	X							

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Education											
Higher Education (San Joaquin Delta College, University of the Pacific, Humphries University, Cal State University Stanislaus)	Provide post-secondary educational opportunities and student services to build skills and enhance economic security.					X			X		
Manteca Give Every Child a Chance	Provides tutoring/homework assistance, science and technology programs, and healthy eating/active living opportunities for low income students.			X					X		
San Joaquin County School Districts (Fourteen including Lodi Unified School District, Manteca Unified School District, Stockton Unified School District, and Tracy Unified School District)	The County's 14 school districts promote a well-rounded education and ensure students have the knowledge/skills necessary for future success. The school districts set policy and performance standards, ensure compliance with laws/regulations, monitor finances, select curricula, and oversee intervention and support services (such as counseling and free and reduced price meals) for students and families.	X	X	X			X		X	X	
San Joaquin County Office of Education and Healthy Kids Resource Center	Supports education of more than 145,000 students enrolled in 14 school districts in the county. The HKRC provides access to educational resources, including health promotion resources, that can be borrowed at no cost.	X	X	X			X		X	X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Community, Families, and Children's Supports											
Amelia Ann Adams Whole Life Center	Empowers women, men and children by providing supportive services, resources, and other tools that create opportunities for individuals and families to overcome their current obstacles.		X	X		X	X	X		X	
Catholic Charities of the Diocese of Stockton	Provides direct social services and advocacy for adults, families and children including: programs for the elderly; a food bank in Stockton; supports for immigrants including family reunification, citizenship application and education; health insurance enrollment, short-term counseling services; youth engagement; Cal Fresh application assistance and environmental justice promotion.	X	X	X		X	X		X	X	
Child Abuse Prevention Council of San Joaquin County	Protects children and strengthens families through awareness and outcome driven programs including childcare, family supports and clinical services, delivered with compassion.	X	X				X				
Community Partnership for Families of San Joaquin	Provides tools, resources, and connections to help families improve their quality of life. Operates Family Resource Centers to build strong, resourceful and financially sufficient families.		X			X	X				

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Family Resource and Referral Center	Clearinghouse for information on child care services, parenting, nutrition, and child safety. Provides child care referrals and administers child care and nutritional resources. Conducts workshops on effective practices of child rearing, child care, and child safety.	X	X	X			X	X		X	
First 5 San Joaquin County	Provides financial support for health, preschool and literacy programs, and fosters the active participation of parents, caregivers, educators and community members in the lives of young children, prenatal to five years old.	X	X	X			X		X	X	
Cultural/Ethnic/LGBTQI Communities											
Asian Pacific Self Development and Residential Association	Provides a residential facility to over 200 Cambodian families as well as social services (including nutrition education, after school, mercury reduction, and recreational programs among others.)	X	X	X	X		X				
El Concilio	Empowers diverse communities to realize their greatest potential through comprehensive and compassionate programs and services that provide outreach, education, counseling, job training, classes, and awareness building of community resources and personal strengths and abilities.	X	X			X	X		X	X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Lao Family Community Empowerment Center	Provides direct service and advocacy programs to support individuals and families, and community engagement and outreach services on behalf of other agencies wanting to reach the Southeast Asian community. Preserves cultural traditions.		X			X	X				
Little Manila Rising	Provides education and leadership development opportunities to preserve and revitalize the Filipino American community. Offers holistic, culturally rooted community healing and after school, environmental justice, martial arts, dance and other programming. Conducts social justice advocacy.		X	X		X	X	X	X		
San Joaquin Pride Center	Serves the LGBTQ community by creating a safe and welcoming space, providing resources that enrich body, mind and spirit, and by educating the public on tolerance and respect for all people within the LGBTQ community.	X	X					X			
Youth Services											
The One-Eighty	Safe place for teens for mentoring, relationship building, and support systems that promote positive youth development through meaningful activities, adolescent		X	X		X	X	X	X		

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
	counseling, gang prevention, and life skills programs.										
Boys and Girls Clubs (Tracy, Manteca, Lodi, Stockton)	Enable young people, especially those with high needs, to reach their full potential as productive, caring, responsible community members. Provide afterschool, academic and health programs, and character and leadership development opportunities for youth.		X	X		X	X	X			
Lord's Gym City Center	Provides a safe and fun environment for youth to build their confidence, form friendships, engage in physical activity and games, and further their educations.		X	X			X	X	X		
Women's Center - Youth and Family Services	Offers a safe haven and place of healing for vulnerable populations in the community. Provides free, confidential services and shelters designed to meet the needs of homeless and runaway youth and victims of domestic violence, sexual assault and human trafficking.	X	X		X		X	X			

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
YMCA of San Joaquin County	Builds youth social skills and relationships and improves health and educational achievement through programs such as youth sports, camp, aquatics, and high school enrichment.		X	X				X	X		
Food Security											
Emergency Food Bank of Stockton/San Joaquin	Families and individuals in need of emergency food assistance can visit the Emergency Food Bank's on-site food pantry. Other programs include: Mobile Farmer's Market, Nutrition on the Move Education Classes, CalFresh outreach, Partner Pantries, and job training.			X		X			X	X	
Women, Infant and Children's Program (WIC), Supplemental Nutrition Program, Tracy, Stockton, Lodi, Manteca	Offers food vouchers, nutrition education and counseling, and health care referrals to low income pregnant or postpartum women, infants and children up to age 5.	X		X					X	X	
Older Adult Services											
Senior Centers in San Joaquin County, e.g., LOEL Senior Center (Lodi), Lolly Hansen Senior Center (Tracy), Manteca Senior Center, Oak Park Senior Citizens Center (Stockton), Stockton PACE Center, City Parks and Recreation Departments	Multi-purpose senior centers serve adults aged 50 and above with a variety of programs to encourage social interaction, promote healthy eating and physical activity, and contribute to overall healthy aging.		X	X			X			X	

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Employment and Economic Assistance											
Energy Assistance Programs (e.g., HEAP, REACH, PG & E)	Assist low income residents with paying utility bills.					X					
San Joaquin County WorkNet	Offers programs specifically designed for individuals seeking employment. At the Lodi and Stockton WorkNet Centers, orientations provide information about training, EDD services, and re-employment supports.					X					
Oral Health											
San Joaquin Treatment & Education for Everyone on Teeth & Health (SJ TEETH) Collaborative	Coalition composed of First 5 San Joaquin, San Joaquin County Public Health Services, dentists, nonprofit organizations, and other partners working together to prevent and treat oral diseases in children, increase awareness of the importance of dental health to overall health, and increase access to dental services.	X		X							
St. Raphael's Free Dental Clinic	Community based dental center that provides free dental services and information/education on dental health and prevention for low income people.	X									
Stockton Unified School-based Dental Program	Provides dental clinics at numerous school sites to students with or without insurance.	X									

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Active Transportation											
San Joaquin Bike Coalition	Advocates for bicycle safety, holds bicycle related events and serves as a hub for the advancement of bicycles in the community. Works with local government to implement bicycle lanes and provides resources for motorists and cyclists.			X				X			X
UC Cooperative Extension of San Joaquin County	Bridges local issues and UC research. Campus-based specialists and county-based farm, home and youth advisors work as teams to bring practical, unbiased, science-based answers to problems. Advocates for healthy communities, promotes nutritious foods and exercise for better health, and provides the 4-H Youth Development Program.		X	X							
Other											
2-1-1 San Joaquin	An online and phone database for referrals to health and social services. Available 24 hours a day, 7 days a week with assistance provided in over 200 languages.	X	X	X	X	X	X	X	X	X	X
California Human Development, San Joaquin Country	Provides job training, affordable housing support, disabilities services, substance abuse treatment/sober living, and immigration	X	X	X	X	X	X				

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
	and citizenship resources. The headquarters are located in Lodi.										
Disability Resource Agency for Independent Living (DRAIL)	Increases the independence of persons with disabilities through services such as housing and personal assistant referral, peer counseling, benefits advising, independent living skills training, and advocacy.	X	X	X	X	X	X				
LOVE, Inc. Manteca	Provides social services through faith-based organizations/churches. Supports ministries to respond to communities' unmet needs including food, clothing, furniture, bicycles, transportation to medical appointments, and prescription assistance.	X	X	X		X	X			X	X
Public Health Advocates, Stockton Office	Helps neighborhoods and schools become places that nurture wellness by creating equitable physical, social, and economic conditions for health. The REACH project promotes healthy eating/physical activity and expanded access to healthy foods in neighborhoods and organizations serving Stockton's African American residents. Engages residents in working with city leaders.		X	X							

Assets/Resources	Description	Access to care	Mental health/ substance use	Chronic disease/HEAL	Housing	Economics	Social support	Community safety	Education	Food security	Transportation
Restore the Delta	Provides public education and outreach to raise awareness of the Sacramento-San Joaquin Delta as a valuable part of the natural environment. Fights for fishable, farmable, swimmable, and drinkable Delta waters. Advocates for water sustainability policies.			X							

San Joaquin County Behavioral Health Services

Drug Medi-Cal Organized Delivery System &
Specialty Mental Health Services

Integrated Quality Assessment & Performance Improvement Program Description and Work Plan

January 1, 2025 – December 31, 2026

(Annual update- 01.01.2026)

San Joaquin County Behavioral Health Services
Quality Assessment and Performance Improvement Program Description and Work Plan

Overview

San Joaquin County Behavioral Health Services (SJCBHS) is committed to the provision of a well-designed and well-implemented Quality Assessment & Performance Improvement (QAPI) Program. Toward this end, SJCBHS has developed and implemented a range of quality assessment & performance improvement activities to monitor, measure and improve the timeliness, access, quality, satisfaction and outcomes of its services, including the following activities:

- Collecting and analyzing data to measure against the goals, or prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which activities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the Quality Assessment & Performance Improvement Council (QAPIC);
- Obtaining input from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services;
- Designing and implementing interventions for improving performance;
- Measuring the effectiveness of the interventions;
- Incorporating successful interventions into SJCBHS' operations as appropriate; and
- Reviewing the results of member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals and clinical record reviews.

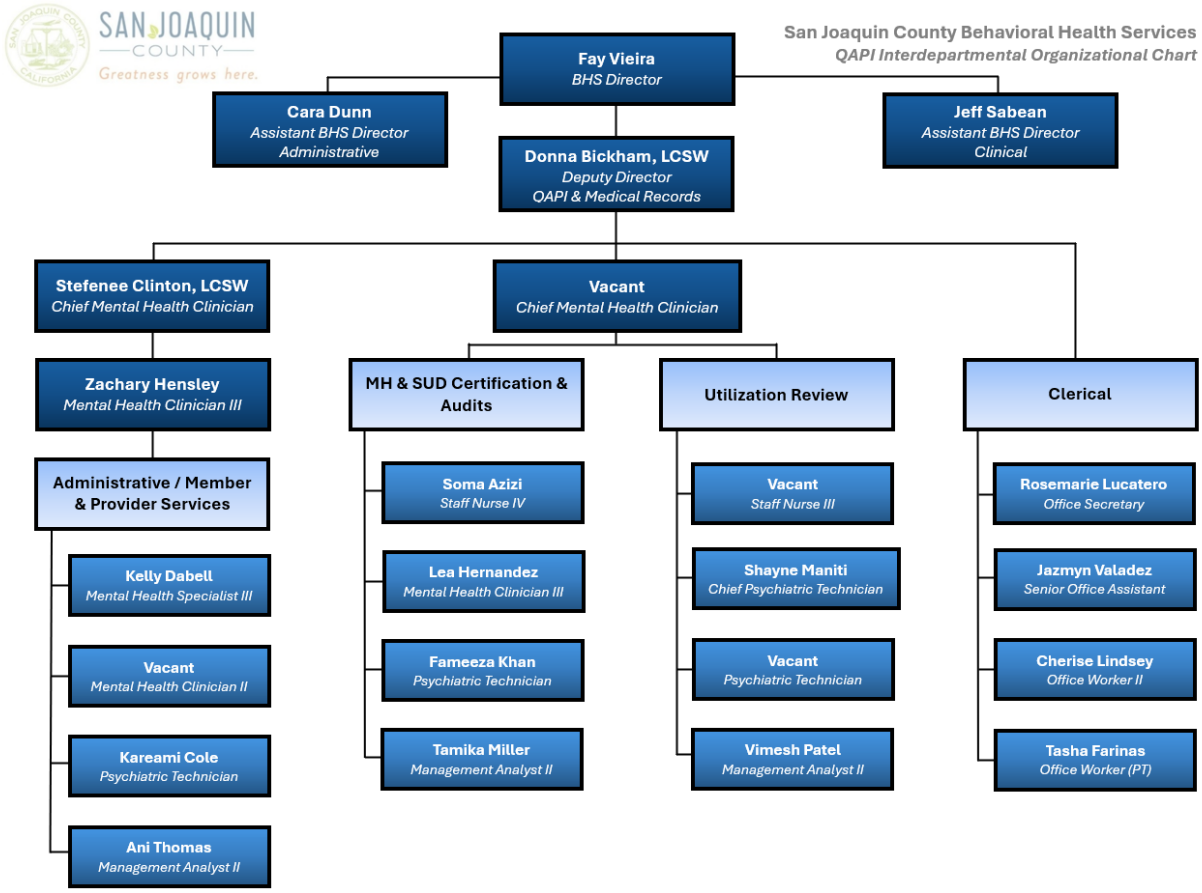
Quality Improvement Principles

SJCBHS' approach to quality improvement is based on the following principles:

- Recovery-oriented: Services provided should promote and preserve wellness and expand choices to meet individually defined goals.
- Stakeholder Empowerment: Effective quality improvement initiatives should involve people at all levels of the organization in improving quality.
- Leadership Involvement: Strong leadership, direction and support of quality improvement activities are essential to performance improvement. Involving organizational leadership assures that quality improvement initiatives are consistent with SJCBHS' mission, vision, and values.
- Data Driven Decision-Making: Successful quality improvement processes should incorporate feedback loops, using data to develop practices and measure results.
- Prevention over Correction: Continuous quality improvement includes designing processes that achieve positive outcomes rather than fixing processes that do not produce desired results.

Program Structure

As an integral component of SJCBHS Administration, the QAPI Office is responsible for overseeing the monitoring of service quality and resource utilization, as well as facilitating improvements in areas identified as deficient. The quality management program is overseen by the Deputy Director of Quality Assessment & Performance Improvement and Medical Records. The department is staffed with Licensed Professionals of the Healing Arts, Nurses, Analysts and support staff.



The quality management department is comprised of five primary functions: administrative, member and provider services, informatics, certification & audits and utilization review.

Administrative Services

Administrative services functions include coordinating External Quality Reviews and audits conducted by the Department of Health Care Services, facilitating the QAPIC meetings, monitoring the implementation and evaluation of the QI Work Plan and serving as a liaison between the managed care plans.

Member and Provider Services
Member and Provider Services staff oversee the grievance and appeals process, ensure the availability of informing materials (including in alternative formats), monitor and update the provider directory, monitor and analyze the results of test calls and process requests to change providers.

Data Analysis
Analysts within the QAPI department at San Joaquin County Behavioral Health Services (SJCBHS) play a vital role in supporting data-driven decision-making processes across mental health and substance use disorder services. The team's primary focus is to ensure accurate, timely, and actionable data collection, validation, and analysis that supports the agency's quality improvement initiatives, compliance requirements, and overall service delivery effectiveness.

Certification and Audits
The department is responsible for certifying and recertifying contract organizations and practice sites to ensure the delivery of appropriate and safe care. QAPI staff members conduct initial visits to these provider sites when the contract commences and subsequently revisit them every annually as part of routine assessments. Additional visits may be scheduled as required to uphold the standards of quality and safety.

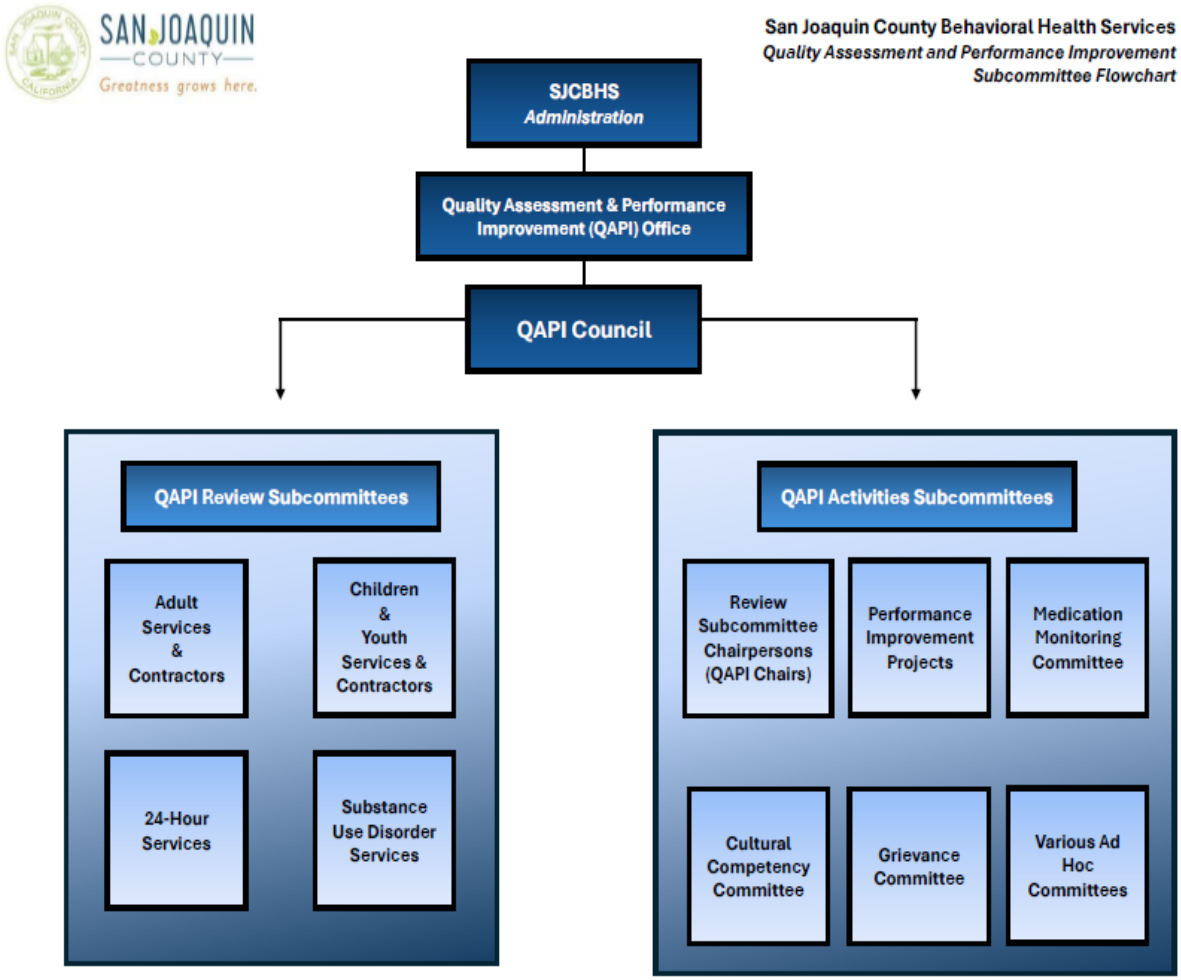
Utilization Management
San Joaquin County Behavioral Health Services (SJCBHS) Utilization Management (UM) program evaluates the medical necessity, appropriateness and efficiency of services provided to Medi-Cal members prospectively or retrospectively. Services evaluated include inpatient, residential and outpatient Specialty Mental Health Services (SMHS), as well as Substance Use Disorder (SUD) residential and outpatient services. Services are reviewed and authorization decisions are made in accordance with state regulations. SMHS and SUD outpatient services are evaluated for detection of overutilization and underutilization of services, fraud, waste and abuse.

Quality Improvement Council
In compliance with requirements established by the Department of Healthcare Services (DHCS), the Quality Assessment & Performance Improvement Council (QAPIC) convenes on a regular basis to thoroughly assess and evaluate the outcomes of the QAPI Review Subcommittees and the QAPI Activities Subcommittees. The QAPIC is tasked with recommending policy decisions, reviewing and evaluating the results of Quality Improvement (QI) activities, including Performance Improvement Projects, instituting needed QI actions, ensuring follow up of QI processes and documenting in QAPI Council meeting minutes decisions and actions taken.

The QAPIC and its committees include Senior Management personnel, Program Managers and/or their delegates, as well as designated providers, members, and family members. It serves as a vital platform for effective communication and information dissemination to stakeholders.

Committees

The QAPI department coordinates and facilitates the Quality Assessment & Performance Improvement Council meetings as well as its subcommittees. The QAPIC and each subcommittee play a crucial role in supporting the growth and development of the organization by assisting in identifying areas for improvement and implementing strategies to achieve higher levels of quality. A description of the QAPIC and each committee is as follows:



Review Subcommittees

To assess the quality of services, SJCBHS employs chart review activities as part of its QAPI Review Subcommittees. These subcommittees are established across various divisions within SJCBHS, and staff members are assigned by Program Managers to serve as active members.

Participation as a QAPI Review Subcommittee member offers valuable learning opportunities for all clinical employees, enabling them to gain a deeper understanding of the overall system. The subcommittees strive to review five percent of charts from their respective areas annually, utilizing

the QAPI Review Subcommittee Worksheet as an assessment tool. The Program Manager or an assigned representative review the completed Worksheet and, if necessary, formulates a Corrective Action Plan of Correction (CAP). The Worksheet and POC are then submitted to the QAPI office. A dedicated QAPI staff member reviews the Worksheet and POC and completes the Multiuse Complete Feedback Loop (McFloop) form. Additionally, QAPI staff conduct a 30-day follow-up if a POC is required. The QAPI Office maintains a comprehensive record of all Worksheets, McFloops, and POCs for reference and documentation purposes.

Activities Subcommittees
The QAPI Activities Subcommittees are comprised of working groups that convene regularly to address concerns identified within the QAPI Review Subcommittees or other relevant platforms. These subcommittees can either be standing committees or formed as Ad Hoc committees to address short-term issues. A description of each subcommittee is as follows:

Performance Improvement Project Subcommittee
The Performance Improvement Project (PIP) Subcommittee focuses on two major projects each year. These projects involve examining the current quality level of services provided and exploring the potential for improvement by implementing specific interventions. The PIP Subcommittee plays a crucial role in supporting the growth and development of the organization by assisting in identifying areas for improvement and implementing strategies to achieve higher levels of quality.

The QAPI Chairs Subcommittee
Routine and consistent oversight of utilization management activities is overseen by the Chart Review Subcommittee, which reports to the QAPIC and ultimately the Executive Staff. Regular meetings of the Chairpersons and committee members are conducted. Within this forum, chairpersons share concerns and issues uncovered by their respective subcommittees. This collaborative effort serves as a valuable means of identifying systemic problems and various types of concerns. Once identified, potential solutions can be explored and implemented. Contractor staff also participate in the QAPI Chairs meeting on a regular basis, ensuring a comprehensive and inclusive approach to addressing these matters.

Grievance and Appeals Committee
The Grievance and Appeals Committee is a subcommittee of the QAPIC and is responsible for tracking and analysis of member grievances and appeals, including type, timeliness of resolution and making recommendations regarding corrective actions as needed. The Committee meets quarterly and provides summary reports to the QAPIC.

Medication Monitoring Committee
The Medication Monitoring Committee monitors the safety and effectiveness of medication practices. This committee meets monthly and reviews a sample size of the medication services provided by the psychiatrist and/or other medical staff and monitors medication practices. Results are directly reviewed with providers, psychiatrists, medication support staff, and the Compliance and QI Coordinator. A summary report is also shared with the QAPIC.

Quality Assessment & Performance Improvement Work Plan

The Quality Assessment & Performance Improvement department and Council facilitate the development and implementation of the QI Work Plan and the QI activities. The QI Work Plan ensures the opportunity for input and active involvement of members, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Assessment and Performance Improvement program. The QI Work Plan addresses quality assurance/improvement initiatives related to the delivery of behavioral health services. The overarching strategies guiding the development and implementation of the work plan include:

1. Collaborating between divisions and disciplines to ensure quality services;
2. Coordinating with SJCBHS divisions and the Information Systems unit, to develop reliable reports that provide monthly data for each initiative's measurable objectives;
3. Reviewing data reports with QAPIC to identify the greatest discrepancies between current findings and goals;
4. Developing real-time strategies to address areas of concern;
5. Implementing Performance Improvement Projects for areas of greatest need;
6. Revising goals annually or as needed to meet regulatory expectations and stakeholder expectations; and
7. Fostering staff participation in and commitment to quality assessment and performance improvement initiatives.

Table of Contents: QAPI Work Plan

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Work Plan at a glance	
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Goal 1: Ensure timely access to services				
Section I: Timeliness (19 Objectives)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Outpatient Non-Urgent, Non-Psychiatry, Adults 21+			
OBJECTIVE 1:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 90% or greater.			
BASELINE	98% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent, Non-Psychiatry, Children & Youth 0-20			
OBJECTIVE 2:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	100% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Follow up – Non-Urgent, Non-Psychiatry Adult 21+			
OBJECTIVE 3:	Offer an appointment within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. **Target**: At least 90% or greater			
BASELINE	93% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Follow up – Non-Urgent, Non-Psychiatry Children & Youth 0-20			
OBJECTIVE 4:	Offer an appointment within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. **Target**: At least 90% or greater			
BASELINE	90% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Psychiatry – Adult 21+			
OBJECTIVE 5:	Offer an appointment within 15 business days of request. **Target**: At least 90% or greater			
BASELINE	93% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Psychiatry – Youth 0-20			
OBJECTIVE 6:	Offer an appointment within 15 business days of request. **Target**: At least 90% or greater			
BASELINE	98% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Psychiatry – Adult 21+			
OBJECTIVE 7:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 90% or greater			
BASELINE	Unable to determine at this time due to requests not being reported on the Network Adequacy Findings Report FY2025-2026.			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates. • Enhance the system to track requests for urgent psychiatry by October 30, 2026.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)

BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Psychiatry – Children/Youth 0-20			
OBJECTIVE 8:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 90% or greater			
BASELINE	Unable to determine at this time due to requests not being reported on the Network Adequacy Findings Report FY2025-2026.			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates. • Enhance the system to track requests for urgent psychiatry by October 30, 2026.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Non-Psychiatry – Adult 21+			
OBJECTIVE 9:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 90% or greater			
BASELINE	100% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)

BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Non-Psychiatry – Children/Youth 0-20			
OBJECTIVE 10:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 90% or greater			
BASELINE	100% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Outpatient Substance Use Disorder Services (Youth 0-17)			
OBJECTIVE 11:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	100% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Outpatient Substance Use Disorder Services (Adult 18+)			
OBJECTIVE 12:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	99% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Residential (Youth 0-17)			
OBJECTIVE 13:	Offer an appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	100% (SUD QI Workplan Evaluation July 2023, Item 2.c)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Residential (Adult 18+)			
OBJECTIVE 14:	Offer an appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	95% (SJCBHS Mental Health Timeliness App CY2025)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Mental Health Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Opioid Treatment Program (Youth 0-17)			
OBJECTIVE 15:	Offer an appointment within 3 business days of request. **Target**: At least 90% or greater			
BASELINE	50% (QAPI Workplan Evaluation CY2025)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Opioid Treatment Program (Adult 18+)			
OBJECTIVE 16:	Offer an appointment within 3 business days of request. **Target**: At least 90% or greater			
BASELINE	98% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Follow-Up Appointments (Youth 0-17)			
OBJECTIVE 17:	Offer an appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	82% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Follow-Up Appointments (Adult 18+)			
OBJECTIVE 18:	Offer an appointment within 10 business days of request for services. **Target**: At least 90% or greater			
BASELINE	87% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Request for Urgent Conditions			
OBJECTIVE 19:	Offer an appointment within 48 hours of request for services without prior authorization; 96 hours with prior authorization. **Target**: At least 90% or greater			
BASELINE	Outpatient 97% (Network Adequacy Findings Report FY2025-2026)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Goal 2: Ensure members have *access* to comprehensive high-quality behavioral health services.

Section II: Access (02 Objectives)

BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Access to After Hours Care			
OBJECTIVE 1:	Members in crisis will receive a crisis intervention within 120 minutes of request. **Target**: 85% or greater			
BASELINE	Adults- 65.75%; Children- 75% (QI Workplan FY 23-24 evaluation)			
ACTION PLAN	• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Quarterly, barriers to timely access and proposed interventions, will be presented to Senior Managers for guidance and discussed at QAPI Council. • At the bi-weekly Timeliness Committee meeting, review data on timely access and identify data that requires updates.			
DATA SOURCE / TIME FRAME	SJCBHS Access Timeliness App. Measured Quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	24-Hour Services Managers and Supervisors			

Section II: Access (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Responsiveness of the Access Line, including with prevalent non-English language(s)			
OBJECTIVE 2:	Calls to the 24/7 Access Line will receive timely and accurate information. **Target**: 100% (business and after hours)			
BASELINE	89% (business hours); 93% (after hours) (QI Work Plan Evaluation July 2024)			
ACTION PLAN	• Conduct monthly monitoring of the responsiveness of the 24/7 Access Line • Monthly, provide feedback to the 24/7 Access Line staff regarding test call findings. • Annually, review the Access to Services training to ensure the information is accurate. • Monthly, request Corrective Action Plans when performance falls below expectation in any area.			
DATA SOURCE / TIME FRAME	Test Call Reports; quarterly and monthly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	24/7 Access Line Staff, Supervisors and Managers; QAPI Managers and Supervisors			

Goal 2 (contd): Ensure members have access to comprehensive *high-quality* behavioral health services.				
Section III: Quality (15 Objectives)				
BHS SYSTEM	☐ **DMC-ODS** ☒ **SMHS** ☐ **BOTH**			
SERVICE CATEGORY	Follow-Up after Emergency Department Visit for Mental Illness (FUM)			
OBJECTIVE 1:	Maintain or increase the percentage of emergency department (ED) visits for which, members 6 years of age or older with a diagnosis of mental illness or any diagnosis of intentional self-harm and had a mental health follow-up service, received follow-up service within 30 days of the ED visit. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: 74.2% (30 days)			
ACTION PLAN	• Ongoing, develop resources for obtaining Emergency Department visit information from local hospitals • Ongoing, develop systems to track follow-up services after an emergency department visit • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities. • Ongoing, work with Managed Care Plans to exchange information			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI/Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Managers and Supervisors, Outpatient Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Follow-Up after Hospitalization for Mental Illness (FUH)			
OBJECTIVE 2:	Maintain or increase the percentage of discharges for which, members 6 years and older who were hospitalized for a diagnosis of mental illness or any diagnosis of intentional self-harm and had a mental health follow-up service, received follow- up within 30 days after discharge. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: 56.3% (30 day follow up)			
ACTION PLAN	• Ongoing, develop systems to track follow-up services after hospitalization • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities • Ongoing, work with Managed Care Plans to exchange information			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI/Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Managers and Supervisors, Outpatient Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
OBJECTIVE 3:	Maintain or increase the percentage of children and adolescents 1-17 years of age who had a new prescription for antipsychotic medication and had documentation of psychosocial care as first-line treatment. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: 85.7%			
ACTION PLAN	• Ongoing, develop systems to track the use of first-line psychosocial care for children and adolescents who had a new prescription for antipsychotics. • Continuously monitor and implement strategies to address any identified barriers. • Ongoing, work with Managed Care Plans to exchange information			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Children and Youth Services Supervisors and Managers; QAPI Supervisors and Managers			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)			
OBJECTIVE 4:	Maintain or increase the percentage of adults 18 years of age and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: 71.7%			
ACTION PLAN	• Explore developing systems to track adherence to medications for individuals with Schizophrenia, such as a medication monitoring system to track refills to identify possible non-adherence by June 30, 2026. • Provide recommendation to QAPI Council on patient education program on the importance of medication adherence, managing side effects, and the risks of discontinuing treatment by October 30, 2026. • Ongoing, work with Managed Care Plans to exchange information			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Outpatient Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Pharmacotherapy of Opioid Use Disorder (POD)			
OBJECTIVE 5:	Maintain or increase the percentage of opioid used disorder (OUD) pharmacotherapy events that lasted at least 180 days, among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: 32.4%			
ACTION PLAN	• Ongoing, develop systems to track pharmacotherapy episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD. • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities. • Ongoing, work with Managed Care Plans to exchange information.			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Substance Use Disorder Services Managers and Supervisors; QAPI Managers and Supervisors			

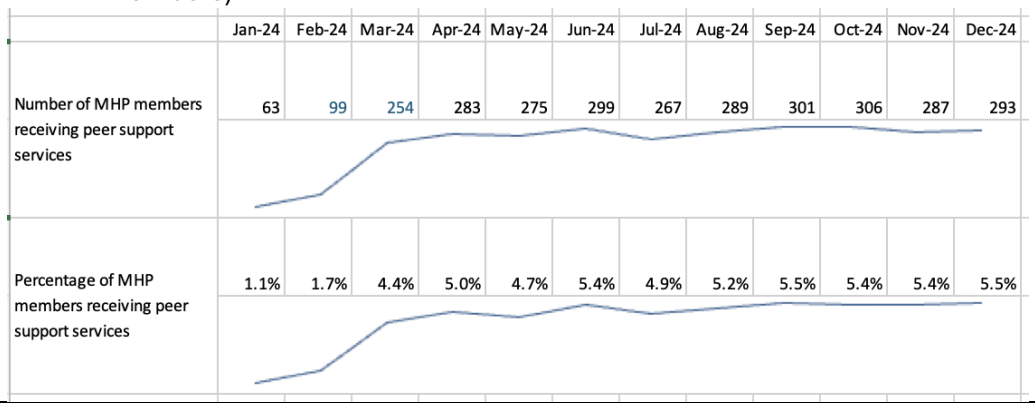
Section III: Quality (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Use of Pharmacotherapy for Opioid Use Disorder (OUD)			
OBJECTIVE 6:	Maintain or increase the percentage of members, aged 18 years and older, who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage an OUD. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: 84.3%			
ACTION PLAN	• Ongoing, develop systems to track the percentage members, aged 18 years and older, who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage an OUD. • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities. • Ongoing, work with Managed Care Plans to exchange information			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Substance Use Disorder Services Managers and Supervisors, QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Initiation and Engagement of Substance Use Disorder (IET)			
OBJECTIVE 7:	Maintain or increase the percentage of new substance use disorder episodes that result in treatment initiation and engagement. Initiation: Episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication management. Engagement: Percentage of new SUD episodes that have evidence of a treatment engagement within 34 days of initiation. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rate from CalMHSA is as follows: Initiation: 41.0% Engagement: 21.9%			
ACTION PLAN	• Ongoing, develop systems to track the percentage of new substance use disorder episodes that result in treatment initiation and engagement. • Ongoing, develop and implement member engagement strategies such as motivational interviewing strategies and outreach for patients who miss appointments. • Ongoing, develop and offer resources such as brochures, videos, and online portals to educate members about behavioral health issues, treatment options, and the importance of ongoing care. • Ongoing, work with Managed Care Plans to exchange information.			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Substance Use Disorder Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Clinical Record Reviews			
OBJECTIVE 8:	Ensure compliance with documentation requirements. **Target**: 90%			
BASELINE	95% (Chart Review Subcommittee Reports – QI Work Plan Evaluation 11/2024)			
ACTION PLAN	• Conduct monthly Utilization Reviews (total 5% of open charts) • Information gleaned from monthly reviews will be presented at the Chart Review Subcommittee meetings. • Continuously, use data analysis to identify trends, gaps in documentation, and opportunities for improvement, and share this information with stakeholders to guide staff development			
DATA SOURCE / TIME FRAME	Chart Review Subcommittee Data/ Monthly, Quarterly and Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Programs; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Develop and implement strategies to reduce avoidable hospitalizations			
OBJECTIVE 9:	Develop and implement strategies to reduce avoidable hospitalizations **Target**: per action plan			
BASELINE	n/a			
ACTION PLAN	• Research, develop and implement a self-management tool designed to improve symptom management by September 30, 2026. • Research and consider implementing tools and strategies aimed at helping members improve their well-being by implementing self-management strategies such as tracking behavior patterns and moods and identifying triggers for increased mental health symptoms by December 30, 2026. • Continuously, offer mental health crisis management support lines to help prevent future emergency visits. • Continuously, educate the community about how to access available outpatient behavioral health services to reduce the need for emergency care. • To research and devise a measurable target by October 30, 2026.			
DATA SOURCE / TIME FRAME	Quality Assessment and Performance Improvement Council meeting minutes/ Bi-monthly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; 24-Hour Services Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section III: Quality (continued)

BHS SYSTEM	☐ **DMC-ODS** ☐ **SMHS** ☒ **BOTH**
SERVICE CATEGORY	Performance Improvement Project: PEER Support Services
OBJECTIVE 10:	Increase the percentage of Behavioral Health Plan (BHP) members who receive at least one Peer Support Service **Target**: • 2025: Collect and monitor CY 2025 data • 2026: Increase over CY 2025 rate
BASELINE	CY 2025 rate not yet available. However, CY2024 monthly rates are: • 0% of DMC-ODS clients • Between 63 and 306 MCP members per month (1.1% and 5.5% of MHP members) 
ACTION PLAN	In 2026, in addition to the workforce development interventions described in 2025, BHS will implement two initiatives: 1) **Welcoming Program**: Three points of entry (BH Access, Adult MH, and Children's System of Care) will implement Welcoming Programs to explicitly introduce peer support benefit to new members. Peer services will be offered as part of the intake process. Intake staff will introduce new members to Peers in waiting rooms. Peers will introduce themselves and offer encouragement, provide help with paperwork, answer questions about the service delivery system and address access barriers.. The PIP evaluator will measure the number and percent of new admissions with Peer Support claims. 2) **Wellness Center Peers**: In 2026, BHS will revise the FY 2026–27 Wellness Center contract to explicitly include peer-led recovery group facilitation within clinical settings, with groups expected to launch later in the contract period. The Wellness Center CBO will train and support peer staff to achieve certification (currently 18 staff), who will then be placed in county clinics to facilitate recovery-oriented group sessions grounded in

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Number of MHP members receiving peer support services	63	99	254	283	275	299	267	289	301	306	287	293
Percentage of MHP members receiving peer support services	1.1%	1.7%	4.4%	5.0%	4.7%	5.4%	4.9%	5.2%	5.5%	5.4%	5.4%	5.5%

	lived experience and mutual support. County clinics will establish supervision standards, provide training and technical assistance, and monitor fidelity and quality, while the Wellness Center retains responsibility for day-to-day supervision of peer staff.			
DATA SOURCE / TIME FRAME	SmartCare service data, analyzed monthly, quarterly and annually. *(Note, annual rates are likely to be significantly higher than monthly rates because over the course of a year, a significantly larger number of clients receive at least one service).*			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Outpatient Services Supervisors and Managers			

Section III: Quality (continued)	
BHS SYSTEM	☐ **DMC-ODS** ☐ **SMHS** ☒ **BOTH**
SERVICE CATEGORY	Performance Improvement Project: (Follow-up after ED visit for Substance Use - (FUA)
OBJECTIVE 11:	Maintain or increase the percentage of members, age 13 and older, who receive a follow up service within 30 days of discharge from an ED for a substance use or drug overdose diagnosis (FUA). **Target**: Increase above MY 2025 baseline in both MY 2026 and 2027
BASELINE	MY2025 rates are not yet available. However, MY 2024 rates from CalMHSA are as follows: • 30-Day FUA rate 52.0% (>National 50th percentile MPL = 36.2%)
ACTION PLAN	• Develop and implement clinical strategies using ADT data. Specific strategies TBD • In the first half of 2026, BHS will launch ED follow-up efforts: 1) **On-site, pre-discharge – St. Joseph Medical Center:** BHS is currently meeting with outreach and social work teams at St. Joseph Medical Center—the highest-volume ED in the county—to clarify roles and responsibilities, prevent service duplication, and ensure continuity of care. The IS department has developed an ED Admission Tracker; pending hospital permissions, BH Access staff will conduct daily rounds, provide field-based screenings, care coordination, and counseling, and document follow-up activities. 2) **On-site, pre-discharge – San Joaquin General Hospital:** BHS has maintained a substance abuse counselor (SAC) at SJGH for several years. Prior to 2026, the SAC conducted screening and referral without EHR documentation. In early 2026, the SAC received documentation training and began billing services. Due to increased demand, BHS will deploy two additional counselors to support pre-discharge follow-up efforts. 3) **Post-discharge follow-up:** In early 2026, two HIEs will begin transmitting ED discharge data to SJCBHS. Access staff will be trained to conduct follow-up by phone and document activities in the ED Discharge Tracker. Follow-up will include supporting clients' return to their care teams, providing screening and navigation assistance, and offering brief SUD contemplative counseling to encourage treatment engagement.
DATA SOURCE / TIME FRAME	Emergency Department ADT data and MCP claims data from one or more Health Information Organization. • ADT data acquired hourly • Claims data acquired monthly

	Interim data from DHCS's Planned Data Feed, provided monthly to CalMHSA (data does not include members not enrolled in BH programs)			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Supervisors and Managers, Outpatient Services Supervisors and Managers			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Readmission to Psychiatric Hospitals			
OBJECTIVE 12:	Develop and implement strategies to maintain or reduce the percentage of members that readmit to an inpatient psychiatric facility within 30 days of discharge. **Target**: Children less than 9% Adults less than 14%			
BASELINE	Children less than 1%; Adults 11% (QI Work Plan Evaluation July 2024)			
ACTION PLAN	• Research, develop and implement a self-management tool designed to improve symptom management by September 30, 2026. • Research and consider implementing tools and strategies aimed at helping members improve their well-being through self-management strategies such as tracking behavior patterns and moods and identifying triggers for increased mental health symptoms by December 30, 2026. • Continuously, offer mental health crisis management support lines to help prevent future emergency visits. • Continuously, educate the community about how to access available outpatient behavioral health services to reduce the need for emergency care.			
DATA SOURCE / TIME FRAME	SmartCare; quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	24-Hour Services Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Develop and implement strategies to coordinate physical, mental health and SUD services.			
OBJECTIVE 13:	Develop and implement strategies to increase the percentage of members whose physical, mental health and SUD services are coordinated. **Target**: per action plan			
BASELINE	n/a			
ACTION PLAN	• Continue ongoing efforts to exchange information with managed care partners. • Develop, implement and monitor a system to refer individuals to and between appropriate systems of care via a coordinated care referral request by August 31, 2026. • Ongoing, implement and monitor a closed loop referral system for transitioning care to and from managed care plans. • Consider implementing the use of Medi-Cal Connect to assist with care coordination activities by September 30, 2026. • Research and devise a measurable target by October 30, 2026.			
DATA SOURCE / TIME FRAME	Quality Assessment and Performance Improvement Council meeting minutes/ Bi-monthly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors;			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Medication Monitoring			
OBJECTIVE 14:	Ensure the safe, effective, and consistent use of medications in behavioral health and substance use disorder services, including psychotropic medications and those used in Medication-Assisted Treatment and Narcotic Treatment Programs. **Target**: Review one chart per prescriber by the end of 2026			
BASELINE	Completed monitoring reports			
ACTION PLAN	• Track medication monitoring activities per SB 1291 • Develop, implement and expand methods to monitor medication prescribed by Oct 1, 2026. • Annually, review one chart per behavioral health services and county contract prescribers.			
DATA SOURCE / TIME FRAME	SJCBHS Medication Monitoring Report/ Quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Medication Monitoring Committee; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Quality Management			
OBJECTIVE 15:	Develop and implement an annual Quality Assessment and Performance Improvement Program Review **Target**: Present recommendations to QAPI Council at the August 2026 meeting Complete review by January 2027			
BASELINE	Completed Annual Evaluation			
ACTION PLAN	• Annually, prepare and distribute an annual evaluation of the Quality Improvement Program and Work Plan to leadership, staff, and stakeholders. • Update the Quality Improvement Work Plan as needed to address emerging issues related to quality improvement.			
DATA SOURCE / TIME FRAME	Completed Assessment January of each year			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors			

Goal 3: To ensure members are satisfied with their services.

Section IV: Satisfaction (03 Objectives)

BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Member Satisfaction			
OBJECTIVE 1:	Increase member satisfaction with services. **Target**: 90% of members will report satisfaction with services			
BASELINE	Consumer Perception Survey (CPS) 2024 (mental health) - 81% of individuals surveyed were satisfied with the overall services in the following domains: Quality, Access, General Satisfaction, Participation in Tx Planning, Social Connectedness, Outcome and Functioning Treatment Perception Survey (TPS) 2024 (substance use services)- 92% of individuals surveyed were satisfied with the overall services in the following domains: Access, Quality, Care Coordination, Outcome and General Satisfaction			
ACTION PLAN	• Develop and implement a plan to communicate Consumer Perception Survey outcomes to members, providers, and other stakeholders by July 31, 2026. • Ongoing, identify and implement strategies to address areas that require improvement. • Implement at least one member focus group survey recommendation by October 30, 2026.			
DATA SOURCE / TIME FRAME	TPS and CPS Surveys/Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section IV: Satisfaction (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Grievances and Appeals			
OBJECTIVE 2:	Develop and implement a system to evaluate grievances, appeals, expedited appeals, state hearings, expedited state hearings and provider appeals. **Target**: Present quarterly analysis at QAPI Council Meetings beginning in February 2025			
BASELINE	Quarterly Reports to QAPI Council			
ACTION PLAN	• Monthly, quarterly and annually by fiscal and calendar year, track, trend, and analyze member grievance, appeal, and State Fair Hearing information, including tracking by type, ethnicity and language. • Ongoing, develop and implement strategies to resolve grievances and appeals within 30 days. • Conduct quarterly Grievance Committee Meetings to review grievances and appeals and make recommendations to address areas of concern. • Develop a new Grievance, Appeal, Suggestion, Complaint and Compliment form and distribute it system-wide by July 01, 2026.			
DATA SOURCE / TIME FRAME	Grievance Committee Reports, Reports to QAPI Council/Quarterly and Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; Grievance Committee Members			

Section IV: Satisfaction (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Request for Change of Providers			
OBJECTIVE 3:	Develop and implement a system to evaluate requests to change persons providing services. **Target**: Present quarterly analysis at QAPI Council Meetings beginning in April 2025			
BASELINE	Quarterly Reports to QAPI Council			
ACTION PLAN	• Quarterly and annually by fiscal and calendar year, track, trend, and analyze change of provider request data by demographics, reasons, location, providers, and language. • Continuously, plan and implement strategies to address any identified barriers. • Ongoing, ensure that 100% of requests to change providers are processed within 30 days.			
DATA SOURCE / TIME FRAME	Change of Provider Reports/Quarterly and Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; Program Managers and Directors			

Goal 4: Identify and implement strategies to increase access and engagement among ethnic/cultural groups that are underserved or inappropriately served.

Section V: Cultural Competency (01 Objective)

BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Cultural Competency			
OBJECTIVE 1:	Develop and implement a Cultural Competence plan to ensure that behavioral health services are accessible, equitable, and effective for individuals from diverse cultural and linguistic backgrounds. **Target**: Complete by December of each year			
BASELINE	Completed Cultural Competence Plan			
ACTION PLAN	• Annually, develop a single Cultural Competence Plan that addresses both individuals with specialty mental health services needs and individuals with substance use disorder needs. • Ongoing, identify and implement strategies and resources to increase access and engagement activities among specified ethnic/cultural groups that are currently unserved, underserved or inappropriately served. • Ongoing, monitor Cultural Competency Training completion rates. • Ongoing, provide language services training to all new employees to ensure members receive services in their preferred language.			
DATA SOURCE / TIME FRAME	Cultural Competence Plan/Quarterly and Annual Progress Updates			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Ethnic Services Manager; Cultural Competence Committee			

QAPI Work Plan Change Log

	Section	Change Description	Revision Date
1	SJCBHS QAPI Program Description	• QAPI Interdepartmental Organizational Chart- Revised • Data Analysis- Revised as • Utilization Management- Rephrased • Review Subcommittees- Rephrased	01.02.2026
2	Timelines Objectives: 1-19	• Target- Revised to 'At least 90% or greater' • Action Plan- Revised analysis timeline to 'Quarterly'	01.02.2026
3	Timeliness Objectives: 1-6, 9, 10-12, 16-19	• Baseline: Updated	
4	Timeliness Objective: 7, 8	• Baseline -Added narrative • Action Plan- Added item	01.02.2026
5	Timeliness Objectives: 11,12, 15, 17, 18	• Baseline- Updated QAPI Workplan CY2025 Evaluation result	01.02.2026
6	Timeliness Objectives: 5, 6, 10	• Objective- Rephrased	01.02.2026
7	Timeliness Objective: 13	• Baseline- Updated SUD QI Workplan Evaluation July 2023, Item 2.c	01.02.2026
8	Access Objective: 1	• Baseline- Updated QI Workplan FY 23-24 Evaluation result • Data Source/ Time Frame - Updated 'SJCBHS Access Timeliness App/ Quarterly' • Action Plan- Revised analysis timeline to 'Quarterly'	01.02.2026
9	Quality Objectives: 1-7	• Baseline- Updated MY2024 (CalMHSA report) aggregated rates as (HEDIS measures)	01.02.2026
10	Quality Objective: 4	• Action plan- Added timeline as 'October 30, 2026' • Action Plan- Rephrased an item	01.02.2026

	Section	Change Description	Revision Date
11	Quality Objectives: 1, 2, 4, 5	• Objective- Reframed per NCQA language	01.02.2026
12	Quality Objectives: 7, 13	• Action Plan- Rephrased	
13	Quality Objective: 9	• Action Plan- Added timeline to 'September'	01.02.2026
14	Quality Objectives: 9, 10, 13	• Action Plan- Added items	01.02.2026
15	Quality Objective: 10	• Action Plan- Deleted an item	01.02.2026
16	Quality Objective: 11	• Baseline- Updated MY2024 (CalMHSA report) aggregated rate • Action Plan- Added items	01.02.2026
17	Quality Objective: 12	• Action Plan- Revised timeline to 'September'	01.02.2026
18	Quality Objective: 14	• Target- Revised to 'Review one chart per prescriber by the end of 2026' • Data Source/ Time Frame - Updated SJCBHS Medication Monitoring Report/ Quarterly • Action Plan- Added timeline to 'October 1, 2026'	01.02.2026
19	Quality Objective: 15	• Target timeframes- revised	01.02.2026
20	Satisfaction Objective: 1	• Baseline- Updated 2024 TPS and CPS survey results • Action Plan- Revised timeline to '2026' • Action Plan- Added an item	01.02.2026

MHSA Prevention and Early Intervention Evaluation Report

San Joaquin County Behavioral Health Services

Fiscal Year 2024/25

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Introduction

In October 2015 the State of California Office of Administrative Law (OAL) approved new Prevention and Early Intervention (PEI) regulations[1,2]. Under these regulations, San Joaquin County Behavioral Health Services (SJCBHS) must submit an annual Prevention and Early Intervention (PEI) Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC). This report has been compiled to meet that requirement.

SJCBHS's PEI Projects are classified into specific Program and Strategy categories per State regulation. Each of these Program and Strategy categories has a specific set of reporting requirements. Table 1 illustrates the distribution of SJCBHS's PEI Projects into these seven Program and Strategy categories:

1. Prevention
2. Intervention
3. Outreach for increasing recognition of early signs of mental illness
4. Stigma and discrimination reduction
5. Suicide prevention
6. Access and linkage to treatment programs
7. Timely access to services for underserved populations

This report includes a brief description of each SJCBHS Project along with the required information for each Program and Strategy, as specified in Section 3560.010 of the California Code of Regulations (CCR).

[1] (CCR, Title 9, 3200.245, 3200.246, 3510.010, 3560, 3560.010, 3560.020, 3700, 3701, 3705, 3706, 3710, 3717, 3720, 3725, 3726, 3730, 3735, 3740, 3745, 3750, 3755, 3755.010),

[2] A copy of the regulations may be found at https://mhsoac.ca.gov/wp-content/uploads/PEI-Regulations_As_Of_July-2018.pdf

Table 1. Program and Strategy Categories

San Joaquin County PEI Projects	Program Category	Required Strategies		
		Help Create Access & Linkage to Treatment	Improve Timely Access to Services for Underserved Populations	Use Strategies that are Non-Stigmatizing and Non-Discriminatory
Skill-Building for Parents and Guardians	Prevention	X	X	X
Mentoring for Transitional Age Youth (TAY)	Prevention	X	X	X
Coping and Resilience Education Services (CARES)	Prevention	X	X	X
Prevention Services for Children 0-5 and Caregivers (0 to 5)	Prevention	X	X	X
Early Intervention to Treat Psychosis (TEIR)	Early Intervention	X	X	X
Community Trauma Services for Adults	Early Intervention	X	X	X
Prevention and Early Intervention for Older Adults	Early Intervention	X	X	X
Misdemeanor Incompetent to Stand Trial (MIST)	Early Intervention	X	X	X
Community Trainings - Outreach	Outreach for Increasing Recognition	X	X	X
Community Trainings - Stigma	Stigma & Discrimination Reduction	X	X	
Suicide Prevention Project	Suicide Prevention	X	X	X
Whole Person Care	Access and Linkage to Treatment		X	X

Key Findings

The following is a summary of key findings.

Prevention Projects

Skill-Building for Parents and Guardians: Three community-based organizations offered 105 courses, served 1,682 individuals, and graduated 886 parents and guardians from evidence-based parenting classes during FY 2024/25.

Transitional Age Youth: In FY 2024/25, two community-based organizations provided evidence-based mentoring to 586 youth aged 16-25 with emotional and behavioral health difficulties. Project-wide, 81% of participants graduated (achieved at least one self-identified goal).

Coping and Resilience Education Services (CARES): BHS's Children and Youth Services (CYS) provided trauma screening and intensive evidence-based skill-building trainings to caregivers and children who had been exposed to trauma. The program served 274 children and 123 caregivers during the fiscal year.

Prevention Services for Children 0-5 and Caregivers (0 to 5): The 0 to 5 project delivered home visit services to 101 children (and 95 of their caregivers) who were at risk of emerging mental health concerns or who had experienced or at risk for trauma or abuse. Twenty caregivers participated in parenting group sessions.

Early Intervention Projects

Early Intervention and Recovery (TEIR): Telecare provided an integrated set of promising practices intended to slow the progression of psychosis to 112 transitional age youth and their family members over the course of the fiscal year.

Community Trauma Services for Adults (Trauma Services): In FY 2024/25, El Concilio provided services to 104 adults who were referred for screening due to trauma history and traumatic stress symptoms. Thirteen clients received direct early intervention services.

Prevention and Early Intervention for Older Adults (PEARLS): This second year of the PEARLS program saw fifty-five older adults engage in evidence-based practices to educate about depression and develop skills for self-sufficiency and more active lives.

Misdemeanor Incompetent to Stand Trial (MIST) Diversion Project (MIST): This first year of the MIST program engaged 151 justice-involved individuals with suspected or diagnosed mental illness. Clients participated in assessment, treatment, and intensive community-based services as a subset of the Forensic Full Service Partnership model.

Outreach for Increasing Early Recognition of Mental Illness & Stigma and Discrimination Reduction Projects

NAMI's Outreach for Increasing Recognition of Early Signs of Mental Illness program: During the FY 2024/25, San Joaquin County's chapter of National Alliance on Mental Illness delivered 15-hour NAMI Provider Education classes to 34 behavioral health providers considered potential responders. **NAMI's Stigma and Discrimination Reduction Program** provided In Our Own Voices presentations, Family to Family and Peer to Peer trainings to 253 participants.

Suicide Prevention

Suicide Prevention Program: During FY 2024/25, the Child Abuse Prevention Council (CAPC) facilitated a Yellow Ribbon Suicide Prevention Campaign in 15 high-risk high schools within the county, reaching 5,450 individuals. The program trained 382 school personnel and 392 youth "gatekeepers," and provided intensive SafeTalk training to 245 community members throughout the county. As a result of 253 individual depression screenings, the Suicide Prevention project referred 23 individuals to a higher level of mental health care.

Access and Linkage to Treatment

Whole Person Care: The Whole Person Care project provided case management to 162 individuals who are high utilizers of health care services and at high risk for untreated mental illness. On average, individuals received 11 service contacts and 14 hours of service. One hundred percent of clients (100%) who received services were engaged in discussions about referrals to other services. Roughly half (37) of those with documented referrals to mental health care were known to have been linked to services (received screening, assessment, or treatment).

Access and Linkage to Treatment Strategy

All Prevention and Early Intervention Programs were required to implement an *Access and Linkage to Treatment Strategy*[3]. The following table provides a summary of fiscal year 2024/25 referrals made by PEI programs to mental health treatment; to County mental health providers in particular; and known linkages to treatment, as defined by having engaged in at least one service within sixty days. In total, there were 259 known referrals to mental health treatment, 227 of which were to County-administered programs, therefore trackable. Among County referrals, 139 individuals engaged in services within 60 days (61%).

	Referrals		Demonstrated Linkage*	Demonstrated Linkage %
	To MH treatment	To County MH treatment	To County MH treatment	
CARES	7	7	6	86%
Skill-Building for Parents and Guardians	32	28	11	39%
Suicide Prevention Individual Screening	23	0	0	-
TAY Mentoring	21	21	9	43%
TEIR	9	5	2	40%
Trauma Services	90	90	73	81%
MIST	1	1	1	100%
Whole Person Care	76	75	37	49%
Grand Total	**259**	**227**	**139**	**61%**

*Engaged in a service within 60 days after referral

Timely Services to Underserved Populations

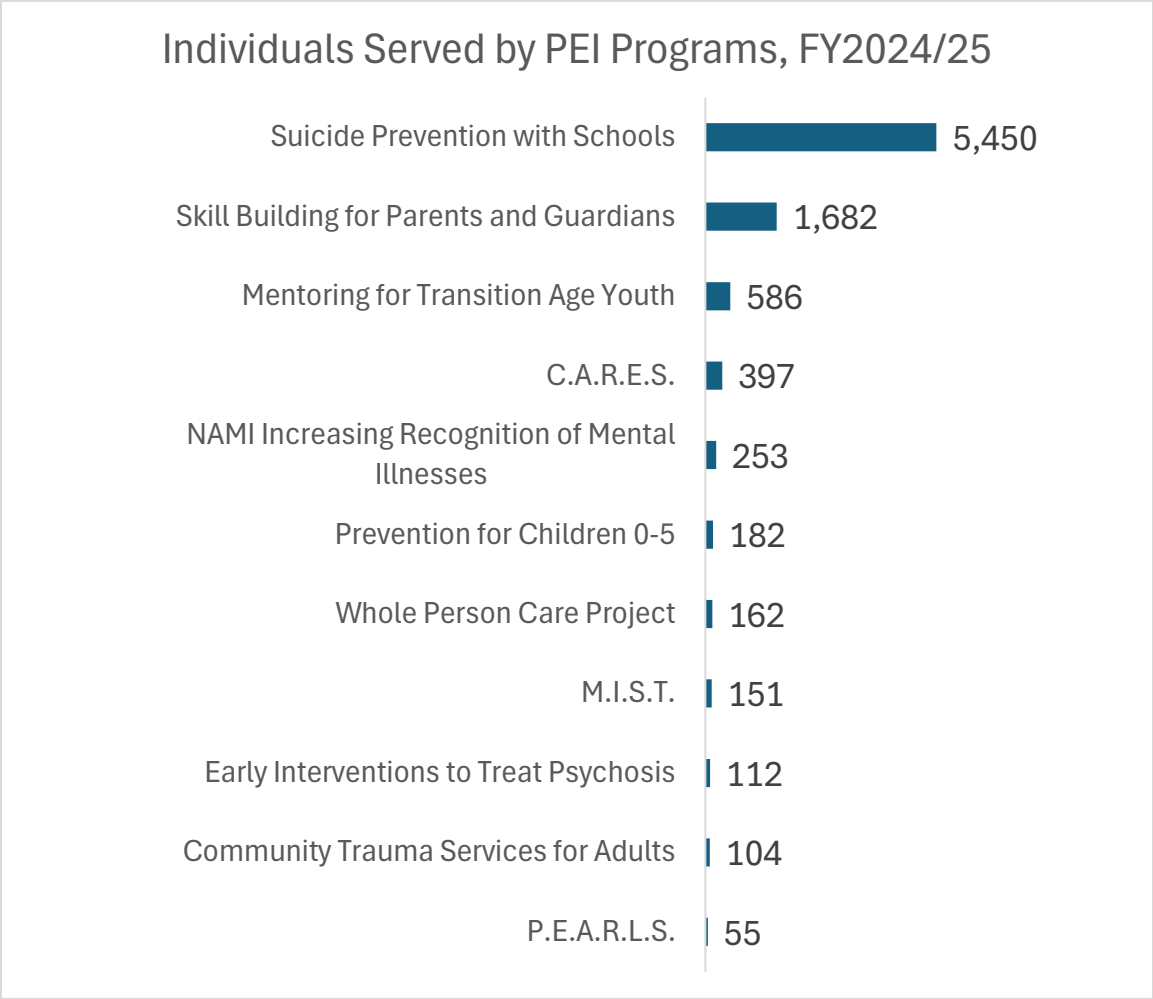
Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

[3] "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs

During FY 2024–25, the PEI projects collectively referred 187 Hispanic/Latino individuals to mental health treatment or another PEI program, representing *55%* of all referrals to mental health treatment or other PEI programs.

Total number of individuals served

The following chart shows the total number of individuals served in each PEI program, for comparative purposes. This graph does not include data related to the intensity of services, thus, a program that serves many participants may provide low touch services and a program that serves relatively few individuals may provide more intensive services. The Suicide Prevention program, for example, provides both low-touch presentations and higher touch depression screenings, referrals, and support groups.



Methods

Each PEI program is expected to keep records of the numbers of individuals served through the various components of programming and to document that information quarterly. When possible, clinical records and billing information were also used to compile the output figures in this report.

Demographic and referral summaries were compiled from demographic surveys and referral information that programs submitted via an online application ("PEI App"). Client IDs (or names and birthdates) were used to match referrals to billed services. Any billed mental health service that transpired within sixty days of referral date was considered a linkage to service[4].

Following state and federal privacy laws, efforts have been made to exclude personally identifiable information. A supplemental file that contains all required data, including that which was excluded from this narrative report, will be submitted to the state under separate cover.

[4] This process of matching provider data to county mental health records could undercount linkages due to discrepancies in how client identifiers were recorded.

Prevention

Skill Building for Parents and Guardians

Project Description

Community-based organizations provide evidence-based parenting classes throughout San Joaquin County to reduce risk factors for mental illness and increase protective factors, including social connectedness, family resilience, and knowledge of child development.

In FY 2024/25, the Skill Building for Parents and Guardians Project was delivered by three community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC) provided Parent Café groups.
- Catholic Charities Diocese of Stockton (CC) provided Nurturing Parenting Program (NPP) groups.
- Parents by Choice (PBC) provided Positive Parenting Program (Triple P) groups.

Project Outputs

In the 2024/25 fiscal year, the Skill Building project served a total of 1,682 parents and guardians. The following table shows that 886 (53%) graduated. Participants attended an average of 5.4 sessions. The table below shows that CAPC served the largest number of participants, Parents by Choice had the highest graduation rate, and the Nurturing Parenting Program provided the highest service intensity (average sessions attended).

Skill-Building for Parents and Guardians				
Outputs FY 2024/25				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Unduplicated parent/guardian participants	839	277	566	1,682
Duplicated parent/guardian participants (sign ins)	4,176	2,063	2,791	9,030
Number of unduplicated individuals who completed/graduated*	296	162	428	886
Total number of groups delivered	45	15	45	105
Total number of sessions delivered	565	209	270	1,044
Average number of participants per group (group size)	7.4	9.9	10.3	8.6
Average number of sessions delivered per group (dosage offered)	12.6	13.9	6.0	9.9
Average number of sessions attended per participant (dosage received)	5.0	7.4	4.9	5.4

*Graduation definitions: For CC-NPP defined as completing at least 7 of the 10 course topics; For PBC defined as attending 80% of Triple P classes and completing Assessment Tool and a Client Satisfaction Survey; for CAPC defined as attending 50% or more of the 15 Parent Café sessions.

Demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compares referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the Skill Building for Parents and Guardians program during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made 32 referrals to mental health treatment. Of the 32 referrals, 28 were for treatment provided, funded, administered, or overseen by County mental health programs. The average duration of untreated mental illness was 12.1 months.
- Of the 28 County-referred individuals, eleven (39%) were known to have engaged in treatment, defined as attending at least one service within 60 days.
- The average interval between referral and service was 23.7 days.

Skill-Building for Parents and Guardians				
Access and Linkage to Treatment Strategy FY 2024/25				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Referrals to MH treatment				
Individuals referred	0	24	8	32
Duration of untreated mental illness (months)	-	-	-	-
Average	-	12.1	NR	12.1
Standard deviation	-	9.8	NR	9.8
(Count of cases with duration data, used to calculate average and SD)	-	20	0	20
Linkages to county administered MH treatment				
Individuals referred to county MH treatment	0	20	8	28
# Engaged*	0	10	1	11
% Engaged	-	50%	13%	39%
Calendar days between referral and service	-	-	-	-
Average	-	20.5	56.0	23.7
Standard deviation	-	17.9	N/A	20.1

*Engaged in a service within 60 days after referral
NR=Not Reported
N/A=Not Applicable

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

During FY 2024–25, the *Skill Building for Parents and Guardians* project referred *38* Hispanic/Latino individuals to mental health treatment or another PEI program, representing *62%* of all *Skill Building for Parents and Guardians* referrals during the period. Of these, *11* individuals were confirmed to have engaged in *services (average of 24 days between referral and service)*.

Skill-Building for Parents and Guardians				
Timely Access to Services for Underserved Populations FY 2024/25				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Total individuals referred to MH treatment or PEI	17	31	13	61
Underserved population: Latino/Hispanic				
Latino/Hispanic individuals referred to MH treatment or PEI	0	31	7	38
Proportion of referrals to MH treatment or PEI	-	100%	54%	62%
Individuals referred to county administered MH treatment	0	20	6	26
Referred individuals who engaged with county administered MH treatment	0	10	1	11
Interval between referral and treatment (days)				
Average	-	21	56	24
Standard deviation	-	17.9	n/a	20.1

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Skill Building for Parents and Guardians Project encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

Mentoring for Transitional Age Youth

Project Description

Community-based organizations provide intensive mentoring and support to transitional age youth (ages 16-25) with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The project targets very high-risk youth to reduce the likelihood of developing serious mental illness associated with adverse childhood experiences, trauma exposure, ongoing stress, family violence, or suicidal ideation.

TAY Mentoring uses the evidence-supported Transition to Independence (TIP) service model. Services focus on the five domains that TIP is designed to impact:

1. Employment and Career
2. Educational Opportunities
3. Living Situation
4. Personal Effectiveness and Wellbeing
5. Community Life Functioning

In FY 2024/25, the Mentoring for Transitional Age Youth (TAY Mentoring) Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- PREVAIL (Pioneering Restoration and Elevating Voices of Advocacy, Idealism and Leadership)

Project Outputs

In FY 2024/25, the TAY Mentoring Project served a total of 586 individuals. The following table shows the number of youths directly served and the number of individual service sessions delivered by each provider. The table also includes TIP model fidelity scores. The Organizational Survey fidelity scores, rated by program managers, are a composite of 9 items related to staffing, services, supervision and other system-level items, and the TIP Practice Probes are a composite of the scores of three interview questions posed to program staff related to their knowledge and practices.

Mentoring for Transitional Age Youth			
Outputs FY 2024/25			
	CAPC	PREVAIL	Total Tay
Unduplicated individuals served	373	213	586
Unduplicated individuals enrolled during fiscal year	303	161	464
Number of individuals who exited program	338	147	485
Number of individuals who graduated*	257	137	394
Percent who graduated	76%	93%	81%
Number of sessions delivered	1,336	1,645	2,981
Average number of sessions delivered per individual	3.6	7.7	5.1
Organizational Survey fidelity scores (average)	95%	88%	91%
TIP Practice Probes fidelity scores (average)	91%	98%	94%

*Graduated=completed at least one self-identified goal

Demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compared referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the TAY Mentoring Project during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 21 participants to mental health treatment, all of which were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 56 months.

- Of the 21 County-referred individuals, nine (43%) were known to have engaged in treatment within 60 days, with an average interval of 14.4 days between referral and treatment.

Mentoring for Transitional Age Youth			
Access and Linkage to Treatment Strategy FY 2024/25			
	CAPC	PREVAIL	Total TAY
Referrals to MH treatment			
Individuals referred	10	11	21
Duration of untreated mental illness (months)	-	-	-
Average	28	120	56
Standard deviation	19.0	121.8	74.1
(Count of cases with duration data, used to calculate average and SD)	7	3	10
Linkages to county administered MH treatment			
Individuals referred to county MH treatment	10	11	21
# Engaged*	5	4	9
% Engaged	50%	36%	43%
Calendar days between referral and service	-	-	-
Average	16.6	11.8	14.4
Standard deviation	17.0	20.9	17.7

*Engaged in a service within 60 days after referral

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

During FY 2024/25, the TAY project referred 11 Hispanic/Latino individuals to mental health treatment or another PEI program, representing 52% of all TAY referrals during the period. Of these, five individuals were confirmed to have engaged in services, with an average of eight days between referral and service initiation.

Additional referral and linkage data for underserved populations are provided in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the TAY program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

Coping and Resilience Education Services (CARES)

Project Description

CYS's CARES project serves children and youth (ages 5-18), and their caregivers, who are at risk for CPS involvement, exposed to trauma, or other risk factors , but who do not meet medical necessity for specialty mental health services. Children and youth are screened for trauma-related symptoms and receive a 12-session evidence-informed intervention to address previous traumas and sustain them through difficult situations. Families receive trauma-informed training using the Parents Reach Achieve and Excel through Empowerment Strategies (PRAXES) curriculum. Children participate in the Child Intensive Model or the Youth Intensive Model. Staff provide one-on-one and group support.

Project Outputs

In the 2024/25 fiscal year, the CARES project served a total of 397 individuals—274 children and 123 parents/caregivers. The following table shows the number referred, screened and served, plus the number who completed the children and youth (CIM/YIM) and parents/caregiver (PRAXES) curriculums.

Coping and Resilience Education Services (CARES)	
Outputs FY 2024/25	
Number of children/youth referred to program	324
Number of children/youth screened into program	213
Number of children served in the program	274
Number of caregivers served in the program	123
Unduplicated number of participants*	**397**
Number of adults who completed PRAXES curriculum	31
Number of children who completed CIM/YIM curriculum	119
Total number of individuals who completed (graduated) from program**	**150**

*Includes rollovers from previous fiscal year

**Not all individuals were expected to graduate within the fiscal year; individuals who began participation later in the year may graduate during the subsequent fiscal year

Demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compared referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the CARES program during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for seven individuals, all of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- Of the seven County-referred individuals, six (86%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 23 days.

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

During FY 2024/25, the *CARES* project referred one Hispanic/Latino individual to mental health treatment or another PEI program, representing 14% of all project referrals during the period. That individual was confirmed to have engaged in services, with six days between referral and service initiation.

Additional referral and linkage data for underserved populations are provided in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the CARES program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

During 2024/25 fiscal year, program staff provided nine presentations to various community-based organizations and child serving systems. The purpose of these presentations was to ensure that agency staff are informed of services available and are educated on how to make referrals or link individuals to mental health services. Staff outreached to 2,812 community members through attendance at various community events, health fairs, and school functions. The purpose of the outreach is to reduce stigma and provide information on how to access services and support available through Behavioral Health.

Prevention Services for Children and Caregivers (age 0 to 5)

Project Description

The 0 to 5 project (Stepping Stones), managed by Victor Community Support Services, serves very young children and their caregivers who are at risk of emerging mental health concerns or who have experienced or at risk for trauma or abuse. Supportive prevention services aim to help children and caregivers build secure attachments, promote healthy development, encourage strong emotional health, and prevent emotional disturbances from taking root. Services consist of monthly and weekly home visits from trained staff who provide parenting education and support for optimal family functioning as well as case management and linkage to other community supports, as appropriate, in addition to group services and other training opportunities to address identified needs.

Project Outputs

In the 2024/25 fiscal year, Stepping Stones enrolled a total of 182 individuals—88 children and 94 parents/caregivers. One hundred and one children (and 95 caregivers) received home visits, with an average of 17 visits per child.

Caregivers also had access to group sessions; twenty parents and caregivers participated in at least one of the twenty-six different sessions.

Prevention Services for Children 0-5 and Caregivers	
Outputs FY 2024/25	
Number of unique (unduplicated) clients, aged 0 to 5, who were referred to services	96
Number of unique (unduplicated) clients, aged 0 to 5, who enrolled in PEI services	88
Number of unique caregivers who enrolled in PEI services	94
Total number of enrolled unique participants	182
Home Visits	
Unduplicated number of caregivers	95
Unduplicated number of children	101
Total number of home visits	1,716
Average number of home visits per child	17
Groups	
Number of Group sessions	26
Number of Group participants (caregiver)	20

Demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compares referral information to electronic health records to track linkages to service. In FY 2024/25the Stepping Stones program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to the population identified as underserved[5].

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the 0 to 5 program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[5] Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Intervention

Early Intervention to Treat Psychosis (TEIR)

Project Description

The Telecare Early Intervention and Recovery Services (TEIR) Project provides an integrated set of promising practices intended to slow the progression of psychosis. The project follows the evidence-based Portland Identification and Early Referral (PIER) model. The project goal is to identify and provide treatment to individuals who have experienced their first psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.

Project Outputs

In FY 2024/25, the TEIR Project provided early intervention services to a total of 112 unduplicated individuals who received an average of 116 hours of service.

The following table shows that over the course of the year 60 individuals were found eligible for TEIR through psychosis screenings. Among these, 48 were admitted to the program to begin receiving services.

Telecare Early Intervention and Recovery Services (TEIR)	
Outputs FY 2024/25	
Number of consumers found eligible for TEIR	60
Number of early psychosis screenings completed (SIPS assessment)	70
Number of admissions	48
Total unduplicated count of individuals receiving early intervention	112
Number of family members who participated in program	106
Total numbers of contacts	9,011
Average number of contacts per individual served	80
Total minutes of service	26,918
Average minutes per individual	6,967
Average hours per individual	116

Demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compares referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the TEIR program during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for nine individuals, five of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- Two (40%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 55 days.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to the population identified as underserved[6].

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the TEIR program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[6] Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Community Trauma Services for Adults

Project Description

Community Trauma Services for Adults (Trauma Services) serves adults who have trauma history and traumatic stress symptoms. The focus is on individuals from low-income communities and communities of color where systemic oppression and social determinants of health have resulted in negative life outcomes. The project goal is to alleviate symptoms, reduce negative outcomes, and improve life functioning for individuals with emerging, mild, or moderate PTSD or related stress disorders. The Trauma Services Project was managed and delivered by El Concilio.

Project Outputs

In the 2024/25 fiscal year, the Trauma Services project served a total of 104 individuals, 90 of whom were screened and referred to a higher level of care. Thirteen clients received direct early intervention services.

Trauma Services	
Outputs FY 2024/25	
Unduplicated count of individuals screened for services	104
Unduplicated count of individuals screened and referred to higher level of care	90
Unduplicated count of participants who received benefit assistance	100
Unduplicated count of participants who received direct early intervention services	13
Total early intervention minutes	1,065
Average number of early intervention minutes per client per week	8.9

Demographic tables from FY 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service, where possible.

The following is a summary of data on mental health treatment referrals from the Trauma Services program during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project made referrals for 90 individuals, all of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- Of the 90 County-referred individuals, 73 (81%) were known to have engaged in treatment within sixty days. Among these individuals who linked to service, the average duration between referral and service was 14.8 days.

Trauma Services	
Access and Linkage to Treatment Strategy FY 2024/25	
Referrals to MH treatment	
Individuals referred	90
Duration of untreated mental illness (months)	
Average	28.6
Standard deviation	28.5
(Count of cases with duration data, used to calculate average and SD)	44
Linkages to county administered MH treatment	
Individuals referred to county MH treatment	90
# Engaged*	73
% Engaged	81%
Calendar days between referral and service	
Average	14.8
Standard deviation	9.7

*Engaged in a service within 60 days after referral

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

During FY 2024/25, the *Trauma Services* project referred *73* Hispanic/Latino individuals to mental health treatment or another PEI program, representing *81*% of all *project* referrals during the period. Of these*, 62* individuals were confirmed to have engaged in services, with an average of *16* days between referral and service initiation.

Additional referral and linkage data for underserved populations are provided in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Trauma Services programs encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

Prevention and Early Intervention for Older Adults

Project Description

The Program to Encourage Active, Rewarding Lives (PEARLS) educates older adults about depression and helps them develop skills they need for self-sufficiency and more active lives. This program takes place in six to eight sessions over the course of four to five months in an older adult's home or a community-based setting that is more accessible and comfortable for older adults who do not see other mental health programs as a good fit for them. The program serves adults aged 60 and older, including individuals from underserved populations such as Latino, Asian, African American, LGBTQ+, low-income, and geographically isolated communities.

Project Outputs

In the 2024/25 fiscal year, PEARLS served a total of 55 individuals, 21 of which enrolled during the fiscal year.

Prevention and Early Intervention for Older Adults	
Outputs FY 2024/25	
Unduplicated count of individuals served	55
Unduplicated count of individuals enrolled in FY 2024/25	21

Demographic tables from FY 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compares referral information to electronic health records to track linkages to service. In FY 2024/25 the PEARLS program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to the population identified as underserved[7].

[7] Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the PEARLS program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

Misdemeanor Incompetent to Stand Trial (MIST)

Project Description

The Misdemeanor Incompetent to Stand Trial (MIST) Diversion Project serves individuals with suspected or diagnosed mental illness who have been found incompetent to stand trial for misdemeanor offenses. The program is a collaboration between San Joaquin County Behavioral Health, the court, probation, the District Attorney, the Public Defender, and community partners. The goal is to provide early identification, behavioral health treatment, and diversion services to individuals whose untreated mental health conditions contribute to justice involvement.

The project provides assessment, treatment, and intensive community-based services as a subset of the Forensic Full Service Partnership model. Services focus on stabilization and engagement in appropriate care in order to reduce the need for state hospital placement, prevent escalation to felony charges, and improve functioning.

The project aims to reduce recidivism and incarceration, prevent homelessness, and support recovery while enhancing public safety through coordinated behavioral health and judicial intervention.

Project Outputs

In the 2024/25 fiscal year, the first year of this new program, MIST served a total of 151 individuals, providing an average of 10.2 hours of service per client.

Misdemeanor IST Diversion	
Outputs FY 2024/25	
	Behavioral Health Services
Total unduplicated individuals served	151
Total numbers of contacts	2,051
Average number of contacts per individual served	13.6
Total minutes of service	92,658
Average minutes per individual	613.6
Average hours per individual	10.2

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compares referral information to electronic health records to track linkages to service.

The MIST program refers clients to additional services when they graduate from the MIST program. In FY 2024/25 the MIST program reported one graduate who was referred to a higher level of mental health treatment. That client was successfully linked to services provided by the county.

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to the population identified as underserved[8].

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the MIST program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[8] Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Outreach for Increasing Recognition of Early Signs of Mental Illness

NAMI Provider Education

Project Description

Outreach for Increasing Recognition of Early Signs of Mental Illness was delivered by National Alliance on Mental Illness San Joaquin (NAMI). NAMI's Provider Education introduces mental health professionals to the unique perspectives of people with mental health conditions and their families. Participants develop enhanced empathy for their daily challenges and recognize the importance of including them in all aspects of the treatment process.

Provider Education is a free, 15-hour program of in-service training taught by a team consisting of an adult with a mental health condition, a family member, and a mental health professional who is also a family member or has a mental health condition themselves.

Project Outputs

NAMI delivered three multi-session Provider Education classes to 34 behavioral health providers.

Outreach for Increasing Recognition of Early Signs of Mental Illness	
Outputs FY 2024/25	
Number of Provider Education Classes	3
Number of potential responders (participants)	34

Demographic tables from 2024/25 are included in the supplemental file.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs were asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service.

This program reported no referrals to a higher level of mental health treatment .

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to the population identified as underserved[9].

[9] Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Stigma and Discrimination Reduction

NAMI Stigma and Discrimination Reduction Program

Project Description

Community Trainings to reduce stigma and discrimination are provided by NAMI volunteers throughout San Joaquin County.

Project Outputs

A total of 253 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2024/25. The following table shows the type and number of each training/workshop offered and the number of individuals reached.

NAMI Stigma and Discrimination Reduction Program		
Outputs FY 2024/25		
	Number of trainings/ workshops	Number of individuals reached
In Our Own Voice (IOOV) 60-90 minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	27	226
Family to Family (F2F) 12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members.	2	13
Peer to Peer (P2P) 10-session class to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery	3	14
TOTAL	32	253

Demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs were asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service.

This program reported no referrals to a higher level of mental health treatment .

Timely Access to Services for Underserved Populations Strategy

The program reported no mental health or PEI referrals to the population identified as underserved[10].

[10] Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Suicide Prevention

Suicide Prevention In Schools

Project Description

The CAPC-led project involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, CAPC provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also provided depression screenings, referrals, and school-based depression support groups.

Project Outputs

In the 2024/25 fiscal year, the Suicide Prevention Project reached 5,450 participants at 15 schools. The following table presents a detailed breakdown of the number of individuals reached by various program activities. The Yellow Ribbon Campaign was the largest component, reaching 4,823 students.

Suicide Prevention in Schools	
Outputs FY 2024/25	
Total reached (duplicated count)	6,129
Total reached (unduplicated count)	5,450
Yellow Ribbon Campaign Messaging	4,823
Be a Link® Adult Gatekeeper Training	382
Ask 4 Help® Youth Gatekeeper Training	392
SafeTalk Training	245
Depression Screening	253
CAST Support Group Participants	34

Demographic tables from 2024/25 are included in the supplemental file.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness or emotional disturbance to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, if any are made, and BHS compared referral information to electronic health records to track linkages to service.

The following is a summary of data on mental health treatment referrals from the Suicide Prevention Individual Screenings during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The Suicide Prevention project made referrals for 23 participants to mental health treatment. These referrals were for treatment provided, funded, administered, or

overseen by non-County mental health programs, and so no data was available regarding linkages to services.

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

During FY 2024/25, the Suicide Prevention project referred 44 Hispanic/Latino individuals to mental health treatment or another PEI program, representing 56% of all Suicide Prevention project referrals during the period. Three of these were referrals to treatment or another PEI program administered by the county. One of the three was confirmed to have engaged in services, with 43 days between referral and service initiation.

Additional referral and linkage data for underserved populations are provided in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Suicide Prevention Project encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment, and PEI programs; and how to document referrals per State regulations.

Access and Linkage to Treatment

Whole Person Care

Project Description

This project provides match funding for San Joaquin County's Whole Person Care Project, approved by DHCS in 2016. The purpose of San Joaquin County's Public Health and Behavioral Health integrated Whole Person Care project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services. Program services target those who frequently utilize emergency department services, have a mental health and/or substance use disorder, or are homeless or at risk for homelessness upon discharge from an institution.

The project involves outreach and engagement by Homeless Outreach Teams who seek to build rapport, provide non Medi-Cal reimbursed services such as transportation to appointments, meals, and other supports to stabilize individuals until they are ready for services, then screens and links them to treatment, as needed.

In FY 2024/25, services were provided by both Public Health Services and the Behavioral Health Department.

Project Outputs

In the 2024/25 fiscal year, the WPC project served 162 individuals, 42 of whom continued services from the prior fiscal year and 120 who initiated services in 2024/25. On average, individuals served through the Behavioral Health Department received 10.6 service contacts and 14.3 hours of service.

Whole Person Care (WPC)			
Outputs FY 2024/25			
	Behavioral Health Services	Public Health Services	Total WPC
Total unduplicated individuals served*	107	55	162
Individuals admitted during fiscal year	65	55	120
Total numbers of contacts	1,133	n/a	n/a
Average number of contacts per individual served	10.6	n/a	n/a
Total minutes of service	92,072	n/a	n/a
Average minutes per individual	860.5	n/a	n/a
Average hours per individual	14.3	n/a	n/a

*Includes individuals continuing services from prior fiscal year
n/a: Public health service level data was not available for reporting (and not required)

Complete demographic tables from 2024/25 are included in the appendix to this report.

Access and Linkage to Treatment Strategy

PEI programs are expected to engage in a strategy to connect individuals with severe mental illness to medically necessary care and treatment. For this reason, programs are asked to document mental health referrals, and BHS compared referral information to electronic health records to track linkages to service.

As a matter of practice, 100% of new clients who received a service from Whole Person Care were engaged in discussions about referrals to various services. The following is a summary of data on mental health treatment referrals[11] documented by the WPC program during the 2024/25 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental file.

- The project documented referrals for 75 individuals to treatment provided, funded, administered, or overseen by County programs.
- Of the 75 BHS County-referred individuals, 37 (49%) were known to have engaged in treatment, defined as attending at least one mental health service within 60 days.
- The average interval between referral and treatment was 9.5 days.

Whole Person Care (WPC)	
Access and Linkage to Treatment Strategy FY 2024/25	
Referrals to MH treatment	
Individuals referred	76
Duration of untreated mental illness (months)	-
Average	66.4
Standard deviation	127.9
(Count of cases with duration data, used to calculate average and SD)	70
Linkages to county administered MH treatment	
Individuals referred to county MH treatment	75
# Engaged*	37
% Engaged	49%
Calendar days between referral and service	-
Average	9.5
Standard deviation	16.4

[11] Because of interconnected nature between mental health and substance use treatment in this population, referrals to SUD treatment were included in counts of mental health referrals

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that Hispanic/Latino community members in San Joaquin County engage in County-administered behavioral health services at lower rates than the overall County population. Based on this disparity, SJBHS identified the Hispanic/Latino population as the focus of its strategy to improve timely access to services.

Hispanic/Latino population

During FY 2024/25, the Whole Person Care project referred 19 Hispanic/Latino individuals to mental health treatment or another PEI program, representing 25% of all project referrals during the period. Of these, nine individuals were confirmed to have engaged in services, with an average of 20.7 days between referral and service initiation.

Homeless population

Because Whole Person Care works closely with unhoused clients, we also looked at timely access for that group as an underserved population. All of the 76 referrals were for clients known to be homeless (100% of all mental health referrals).

A total of 37 of these individuals were known to have engaged in treatment, with an average interval of 9.5 days between referral and service.

More detailed referral and linkage data for underserved populations are included in the supplemental file.

Encouraging Access to Services and Follow Through

San Joaquin County Behavioral Health Services and the Whole Person Care program encourage access to services and follow through by training staff on how to make referrals to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations. Additionally, WPC case managers provide warm handoffs to help clients link to services to which they are referred.

Appendix: Demographic Tables

Skill-Building for Parents and Guardians

Methodological note: Data on demographic groups with fewer than 10 members in any program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Skill-Building for Parents and Guardians				
Demographics FY 2024/25				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Number of demographic forms collected	843	308	631	1,782
Age				
0-15	X	X	X	10
16-25	47	X	25	77
26-59	510	254	435	1199
60 and older	44	14	11	69
Decline to answer	239	29	159	427
Race				
American Indian or Alaska Native	X	X	X	14
Asian	15	X	13	28
Black of African American	41	X	34	77
Native Hawaiian or other Pacific Islander	X	X	X	X
White	139	69	100	308
Other	52	X	42	97
More than one race	281	130	247	658
Decline to answer	304	101	189	594
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	35	X	15	57
Mexican/Mexican-American	362	256	247	865
Puerto Rican	X	X	X	X
South American	X	X	X	13
Other Hispanic or Latino	17	X	X	20
Non-Hispanic or Non-Latino				
African	21	X	22	44
Asian Indian/South Asian	X	X	X	11
Cambodian	X	X	X	X
Chinese	X	X	X	X

Eastern European	X	X	X	X
European	X	X	15	18
Filipino	X	X	X	10
Japanese	X	X	X	X
Korean	X	X	X	X
Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	50	X	60	110
Other	X	X	X	X
More than one ethnicity	47	X	41	89
Decline to Answer	284	37	206	527
Primary language				
English	271	31	315	617
Spanish	329	245	145	719
Other	X	X	X	12
Decline to Answer	238	31	165	434
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	501	185	405	1091
Bisexual	14	X	11	25
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	324	116	208	648
N/A	X	X	X	X
Disability*				
Difficulty seeing	52	X	12	71
Difficulty hearing	17	X	X	20
A mental disability	27	X	24	51
A physical/mobility disability	29	X	X	41
A chronic health condition	30	X	12	48
Other Disability	11	X	X	18
Decline to answer	293	88	185	566
No Disability	431	203	397	1031
Veteran status				
Yes	X	X	12	19
No	577	258	444	1279
Decline to answer	256	44	174	474
N/A	X	X	X	10
Sex assigned at birth				

Male	83	34	107	224
Female	525	243	362	1130
Decline to answer	235	31	162	428
Gender identity				
Male	79	32	107	218
Female	518	242	360	1120
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	243	32	163	438
N/A	X	X	X	X
Homeless				
Yes	146	X	19	165
No	443	263	437	1143
Decline to answer	254	45	175	474

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

Mentoring for Transitional Age Youth

Methodological note: Data on demographic groups with fewer than 10 members in any program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Mentoring for Transitional Age Youth			
Demographics FY 2024/25			
	CAPC	PREVAIL	Total TAY
Number of demographic forms collected	343	149	492
Age			
0-15	X	X	X
16-25	341	149	490
26-59	X	X	X
60 and older	X	X	X
Decline to answer	X	X	X
Race			
American Indian or Alaska Native	X	X	X
Asian	19	X	21
Black of African American	79	57	136
Native Hawaiian or other Pacific Islander	X	X	X
White	92	22	114
Other	55	16	71
More than one race	87	37	124
Decline to answer	X	11	19
Ethnicity			
Hispanic or Latino			
Caribbean	X	X	X
Central America	X	X	X
Mexican/Mexican-American	154	50	204
Puerto Rican	X	X	X
South American	X	X	X
Other Hispanic or Latino	X	X	X
Non-Hispanic or Non-Latino			
African	60	16	76
Asian Indian/South Asian	X	X	X
Cambodian	X	X	X
Chinese	X	X	X
Eastern European	X	X	X
European	10	X	10
Filipino	11	X	14

Japanese	X	X	X
Korean	X	X	X
Middle Eastern	X	X	X
Vietnamese	X	X	X
Other Non-Hispanic or Latino	X	X	15
Other	X	X	X
More than one ethnicity	50	10	60
Decline to Answer	15	59	74
Primary language			
English	288	142	430
Spanish	51	X	58
Other	X	X	X
Decline to Answer	X	X	X
Sexual orientation			
Gay or Lesbian	13	X	17
Heterosexual or Straight	270	131	401
Bisexual	25	X	30
Questioning or unsure of sexual orientation	X	X	10
Queer	X	X	X
Other	X	X	X
Decline to answer	16	X	20
N/A	X	X	X
Disability*			
Difficulty seeing	X	X	X
Difficulty hearing	X	X	X
A mental disability	30	18	48
A physical/mobility disability	X	X	11
A chronic health condition	X	X	X
Other Disability	X	X	X
Decline to answer	12	12	24
No Disability	287	113	400
Veteran status			
Yes	X	X	X
No	341	140	481
Decline to answer	X	X	X
N/A	X	X	X
Sex assigned at birth			
Male	128	71	199
Female	215	78	293
Decline to answer	X	X	X
Gender identity			

Male	127	69	196
Female	205	77	282
Transgender	X	X	X
Genderqueer/Non-Binary	X	X	X
Questioning or unsure of gender identity	X	X	X
Other	X	X	X
Decline to answer	X	X	X
N/A	X	X	X
Homeless			
Yes	26	82	108
No	312	25	337
Decline to answer	X	42	47

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

Coping and Resilience Education Services (CARES)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Coping and Resilience Education Services (CARES)	
Demographics FY 2024/25	
Number of demographic forms collected	308
Age	
0-15	198
16-25	19
26-59	86
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	16
Native Hawaiian or other Pacific Islander	X
White	132
Other	57
More than one race	52
Decline to answer	43
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	169
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X
Middle Eastern	X

Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	38
Decline to Answer	58
Primary language	
English	225
Spanish	74
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	124
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	24
N/A	154
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	14
Decline to answer	29
No Disability	247
Veteran status	
Yes	X
No	104
Decline to answer	X
N/A	198
Sex assigned at birth	
Male	114
Female	185
Decline to answer	X
Gender identity	
Male	36
Female	117
Transgender	X

Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	154
Homeless	
Yes	12
No	291
Decline to answer	X

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

Prevention Services for Children 0-5 and Caregivers (0 to 5)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Prevention Services for Children 0-5 and Caregivers	
Demographics FY 2024/25	
Number of demographic forms collected	96
Age	
0-15	96
16-25	X
26-59	X
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	21
Native Hawaiian or other Pacific Islander	X
White	15
Other	22
More than one race	34
Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	38
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	19
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X
Middle Eastern	X

Vietnamese	X
Other Non-Hispanic or Latino	12
Other	X
More than one ethnicity	15
Decline to Answer	X
Primary language	
English	83
Spanish	11
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	X
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	X
N/A	96
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	X
No Disability	91
Veteran status	
Yes	X
No	X
Decline to answer	X
N/A	96
Sex assigned at birth	
Male	54
Female	42
Decline to answer	X
Gender identity	
Male	X
Female	X
Transgender	X

Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	96
Homeless	
Yes	X
No	91
Decline to answer	X

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

Telecare Early Intervention and Recovery Services (TEIR)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Telecare Early Intervention and Recovery Services (TEIR)	
Demographics FY 2024/25	
Number of participants (unduplicated, including those rolled over from the previous year)	112
Number of demographic forms collected	64
Age	
0-15	X
16-25	46
26-59	X
60 and older	X
Decline to answer	15
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	14
Native Hawaiian or other Pacific Islander	X
White	X
Other	12
More than one race	X
Decline to answer	17
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	14
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	13
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X

Filipino	X
Japanese	X
Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	16
Primary language	
English	47
Spanish	X
Other	X
Decline to Answer	15
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	26
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	20
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	18
No Disability	30
Veteran status	
Yes	X
No	45
Decline to answer	16
N/A	X
Sex assigned at birth	
Male	25
Female	22
Decline to answer	17

Gender identity	
Male	23
Female	22
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	16
N/A	X
Homeless	
Yes	X
No	44
Decline to answer	15

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

Community Trauma Services for Adults

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Trauma Services	
Demographics FY 2024/25	
Number of demographic forms collected	97
Age	
0-15	X
16-25	16
26-59	72
60 and older	X
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	X
Other	X
More than one race	81
Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	77
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X

Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	12
Other	X
More than one ethnicity	X
Decline to Answer	X
Primary language	
English	47
Spanish	48
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	94
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	X
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	13
No Disability	84
Veteran status	
Yes	X
No	93
Decline to answer	X
N/A	X
Sex assigned at birth	
Male	31
Female	64
Decline to answer	X

Gender identity	
Male	31
Female	64
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	X
Homeless	
Yes	X
No	94
Decline to answer	X

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

Prevention and Early Intervention for Older Adults (PEARLS)

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Prevention and Early Intervention for Older Adults	
Demographics FY 2024/25	
Number of demographic forms collected	21
Age	
0-15	X
16-25	X
26-59	X
60 and older	20
Decline to answer	X
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	12
Other	X
More than one race	X
Decline to answer	X
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X

Korean	X
Middle Eastern	X
Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	X
Primary language	
English	19
Spanish	X
Other	X
Decline to Answer	X
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	21
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	X
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	10
Other Disability	X
Decline to answer	X
No Disability	X
Veteran status	
Yes	X
No	21
Decline to answer	X
N/A	X
Sex assigned at birth	X
Male	X
Female	15
Decline to answer	X

Gender identity	
Male	X
Female	15
Transgender	X
Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	X
N/A	X
Homeless	
Yes	X
No	21
Decline to answer	X

NAMI Outreach for Increasing Recognition of Early Signs of Mental Illness

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Outreach for Increasing Recognition of Early Signs of Mental Illness	
Demographics FY 2024/25	
Number of demographic forms collected	33
Age	
0-15	X
16-25	X
26-59	15
60 and older	X
Decline to answer	17
Race	
American Indian or Alaska Native	X
Asian	X
Black of African American	X
Native Hawaiian or other Pacific Islander	X
White	X
Other	X
More than one race	X
Decline to answer	18
Ethnicity	
Hispanic or Latino	
Caribbean	X
Central America	X
Mexican/Mexican-American	X
Puerto Rican	X
South American	X
Other Hispanic or Latino	X
Non-Hispanic or Non-Latino	
African	X
Asian Indian/South Asian	X
Cambodian	X
Chinese	X
Eastern European	X
European	X
Filipino	X
Japanese	X
Korean	X
Middle Eastern	X

Vietnamese	X
Other Non-Hispanic or Latino	X
Other	X
More than one ethnicity	X
Decline to Answer	19
Primary language	
English	15
Spanish	X
Other	X
Decline to Answer	17
Sexual orientation	
Gay or Lesbian	X
Heterosexual or Straight	13
Bisexual	X
Questioning or unsure of sexual orientation	X
Queer	X
Other	X
Decline to answer	17
N/A	X
Disability*	
Difficulty seeing	X
Difficulty hearing	X
A mental disability	X
A physical/mobility disability	X
A chronic health condition	X
Other Disability	X
Decline to answer	17
No Disability	15
Veteran status	
Yes	X
No	16
Decline to answer	17
N/A	X
Sex assigned at birth	
Male	X
Female	13
Decline to answer	18
Gender identity	
Male	X
Female	13
Transgender	X

Genderqueer/Non-Binary	X
Questioning or unsure of gender identity	X
Other	X
Decline to answer	17
N/A	X
Homeless	
Yes	X
No	16
Decline to answer	17

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

NAMI Stigma and Discrimination Reduction Program

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

NAMI Stigma and Discrimination Reduction Program				
Demographics FY 2024/25				
	IOOV	F2F	P2P	Total
Number of demographic forms collected	260	32	22	314
Age				
0-15	X	X	X	X
16-25	52	X	X	55
26-59	79	13	17	109
60 and older	28	X	X	34
Decline to answer	101	12	X	116
Race				
American Indian or Alaska Native	X	X	X	X
Asian	10	X	X	11
Black of African American	12	X	X	15
Native Hawaiian or other Pacific Islander	X	X	X	X
White	70	13	12	95
Other	35	X	X	41
More than one race	22	X	X	25
Decline to answer	106	13	X	122
Ethnicity				
Hispanic or Latino				
Caribbean	X	X	X	X
Central America	X	X	X	X
Mexican/Mexican-American	42	X	X	52
Puerto Rican	X	X	X	X
South American	X	X	X	X
Other Hispanic or Latino	X	X	X	X
Non-Hispanic or Non-Latino				
African	X	X	X	X
Asian Indian/South Asian	X	X	X	X
Cambodian	X	X	X	X
Chinese	X	X	X	X
Eastern European	X	X	X	X
European	16	X	X	21
Filipino	X	X	X	X
Japanese	X	X	X	X
Korean	X	X	X	X

Middle Eastern	X	X	X	X
Vietnamese	X	X	X	X
Other Non-Hispanic or Latino	11	X	X	12
Other	X	X	X	X
More than one ethnicity	27	X	X	33
Decline to Answer	140	15	X	160
Primary language				
English	134	19	16	169
Spanish	26	X	X	29
Other	X	X	X	X
Decline to Answer	97	12	X	112
Sexual orientation				
Gay or Lesbian	X	X	X	X
Heterosexual or Straight	128	13	14	155
Bisexual	11	X	X	16
Questioning or unsure of sexual orientation	X	X	X	X
Queer	X	X	X	X
Other	X	X	X	X
Decline to answer	103	14	X	121
N/A	X	X	X	X
Disability*				
Difficulty seeing	13	X	X	14
Difficulty hearing	15	X	X	15
A mental disability	57	X	12	71
A physical/mobility disability	25	X	X	29
A chronic health condition	19	X	X	23
Other Disability	X	X	X	X
Decline to answer	114	14	X	131
No Disability	70	15	X	91
Veteran status				
Yes	X	X	X	10
No	156	18	17	191
Decline to answer	97	12	X	113
N/A	X	X	X	X
Sex assigned at birth				
Male	67	X	X	73
Female	100	18	14	132
Decline to answer	93	13	X	109
Gender identity				
Male	65	X	X	72

Female	98	17	13	128
Transgender	X	X	X	X
Genderqueer/Non-Binary	X	X	X	X
Questioning or unsure of gender identity	X	X	X	X
Other	X	X	X	X
Decline to answer	94	12	X	109
N/A	X	X	X	X
Homeless				
Yes	29	X	X	32
No	131	20	14	165
Decline to answer	100	12	X	117

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Suicide Prevention in Schools

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Suicide Prevention in Schools		
Demographics FY 2024/25		
	Presentations	Individual Screening
Number of demographic forms collected	6,119	287
Age		
0-15	2,889	142
16-25	1,849	137
26-59	390	X
60 and older	46	X
Decline to answer	943	X
Race		
American Indian or Alaska Native	94	X
Asian	810	11
Black of African American	364	22
Native Hawaiian or other Pacific Islander	106	2
White	1,086	95
Other	1,098	53
More than one race	1,124	81
Decline to answer	1,437	19
Ethnicity		
Hispanic or Latino		
Caribbean	20	X
Central America	107	X
Mexican/Mexican-American	1918	140
Puerto Rican	49	X
South American	46	X
Other Hispanic or Latino	106	X
Non-Hispanic or Non-Latino		
African	149	12
Asian Indian/South Asian	220	X
Cambodian	103	X
Chinese	53	X
Eastern European	57	X
European	195	13
Filipino	177	X
Japanese	11	X

Korean	X	X
Middle Eastern	76	X
Vietnamese	69	X
Other Non-Hispanic or Latino	X	X
Other	240	X
More than one ethnicity	729	28
Decline to Answer	1,788	63
Primary language		
English	3,883	206
Spanish	890	64
Other	261	X
Decline to Answer	1,085	10
Sexual orientation		
Gay or Lesbian	139	11
Heterosexual or Straight	3,866	202
Bisexual	270	18
Questioning or unsure of sexual orientation	76	12
Queer	32	X
Other	67	X
Decline to answer	1,667	37
N/A	X	X
Disability*		
Difficulty seeing	272	19
Difficulty hearing	66	X
A mental disability	153	19
A physical/mobility disability	38	X
A chronic health condition	68	X
Other Disability	60	X
Decline to answer	1,409	31
No Disability	4,154	218
Veteran status		
Yes	19	X
No	2,206	136
Decline to answer	1,003	X
N/A	2,891	142
Sex assigned at birth		
Male	2,308	94
Female	2,734	183
Decline to answer	1,077	10
Gender identity		
Male	2,308	93

Female	2,673	169
Transgender	24	X
Genderqueer/Non-Binary	36	X
Questioning or unsure of gender identity	14	X
Other	X	X
Decline to answer	1,053	13
N/A	X	X
Homeless		
Yes	35	X
No	4,980	272
Decline to answer	1,104	13

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Whole Person Care

Methodological note: Data on demographic groups with fewer than 10 members are not made available to the public and are therefore not included in this report. More detailed demographic data are included in the supplemental report to the State.

Whole Person Care (WPC)			
Demographics FY 2024/25			
	Behavioral Health Services	Public Health Services	Total WPC
Number of demographic forms collected	81	55	136
Age			
0-15	X	X	X
16-25	X	X	12
26-59	69	42	111
60 and older	X	X	13
Decline to answer	X	X	X
Race			
American Indian or Alaska Native	X	X	X
Asian	X	X	X
Black of African American	14	X	23
Native Hawaiian or other Pacific Islander	X	X	X
White	37	17	54
Other	X	X	X
More than one race	14	X	16
Decline to answer	X	18	24
Ethnicity			
Hispanic or Latino			
Caribbean	X	X	X
Central America	X	X	X
Mexican/Mexican-American	19	18	37
Puerto Rican	X	X	X
South American	X	X	X
Other Hispanic or Latino	X	X	X
Non-Hispanic or Non-Latino			
African	X	X	X
Asian Indian/South Asian	X	X	X
Cambodian	X	X	X
Chinese	X	X	X
Eastern European	X	X	X
European	15	X	15
Filipino	X	X	X

Japanese	X	X	X
Korean	X	X	X
Middle Eastern	X	X	X
Vietnamese	X	X	X
Other Non-Hispanic or Latino	13	15	28
Other	X	X	X
More than one ethnicity	X	X	X
Decline to Answer	19	17	36
Primary language			
English	79	53	132
Spanish	X	X	X
Other	X	X	X
Decline to Answer	X	X	X
Sexual orientation			
Gay or Lesbian	X	X	X
Heterosexual or Straight	77	X	77
Bisexual	X	X	X
Questioning or unsure of sexual orientation	X	X	X
Queer	X	X	X
Other	X	X	X
Decline to answer	X	26	27
N/A	X	29	29
Disability*			
Difficulty seeing	X	X	X
Difficulty hearing	X	X	X
A mental disability	12	X	17
A physical/mobility disability	10	X	16
A chronic health condition	15	14	29
Other Disability	X	12	16
Decline to answer	X	11	16
No Disability	44	21	65
Veteran status			
Yes	X	X	X
No	78	45	123
Decline to answer	X	X	10
N/A	X	X	X
Sex assigned at birth			
Male	29	39	68
Female	52	12	64
Decline to answer	X	X	X
Gender identity			

Male	28	36	64
Female	52	12	64
Transgender	X	X	X
Genderqueer/Non-Binary	X	X	X
Questioning or unsure of gender identity	X	X	X
Other	X	X	X
Decline to answer	X	X	X
N/A	X	X	X
Homeless			
Yes	75	46	121
No	X	X	X
Decline to answer	X	X	X

*Mental or physical impairment lasting more than X months and limiting major life activity but is not the result of a severe mental illness

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Board of Supervisors Certification

Certification

1. San Joaquin County Board of Supervisors certifies the following:

   ☑ San Joaquin County Board of Supervisors has reviewed and approved this Integrated Plan for the period of 2026-2029

   ☑ County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists

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

   ○ Yes

   ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with their realignment obligations (optional)

Signature

3. Printed name

   Fay Vieira, LMFT

4. Title

   Behavioral Health Director

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5. Date

7/14/2026

6. Signature

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County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - ✓ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - ✓ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - ✓ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ○ Yes
   - ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

DHCS | County Portal

Signature

3. Print name

Sandra Regalo

4. Date

3/5/2024

5. Signature

Sandra Regalo

Contact information

6. County Name

San Joaquin County

7. Certification for

- (●) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

7a. Submission type

- (●) Draft

8. County Chief Administration Officer Name

Sandra Regalo

9. County Chief Administration Officer Phone number

(209) 468-3417

10. County Chief Administration Officer Email

sregalo@sjgov.org

Before the Board of Supervisors

County of San Joaquin, State of California

B-26-328

Approval of 2026-2029 Behavioral Health Services Act Three-Year Integrated Plan Totaling $295,750,706 for the Period of July 1, 2026, to June 30, 2029

THIS BOARD OF SUPERVISORS DOES HEREBY

1. Accept an oral presentation on the 2026-2029 Behavioral Health Services Act Three-Year Integrated Plan;

2. Approve the 2026-2029 Behavioral Health Services Act Three-Year Integrated Plan totaling $295,750,706 for the period of July 1, 2026 to June 30, 2029; and

3. Authorize the Behavioral Health Services Director or designee to execute necessary program documents related to the 2026-2029 Behavioral Health Services Act Three-Year Integrated Plan, including the submission of corrections, clarifications and technical changes, provided that any changes do not result in additional material costs to the County.

I HEREBY CERTIFY that the above order was passed and adopted on June 2, 2026 by the following vote of the Board of Supervisors, to wit:

MOTION: Gardea/Canepa 5-0

AYES: **Gardea, Canepa, Dhaliwal, Ding, Rickman**

NOES: **None**

ABSENT: **None**

ABSTAIN: **None**

ATTEST: RACHÉL DeBORD
Clerk of the Board of Supervisors
County of San Joaquin
State of California

By: Rachél DeBord

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Board of Supervisors Certification

Certification

1. San Joaquin County Board of Supervisors certifies the following:

   ☑ San Joaquin County Board of Supervisors has reviewed and approved this Integrated Plan for the period of 2026-2029

   ☑ County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists

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

   ○ Yes

   ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with their realignment obligations (optional)

Signature

3. Printed name

   Fay Vieira, LMFT

4. Title

   Behavioral Health Director

DHCS | County Portal

5. Date

7/14/2026

6. Signature