



COUNTY OF SANTA CLARA
Behavioral Health Services

Updates to Key Priorities & Initiatives for Behavioral Health Services

February 10, 2026, Board of Supervisors Meeting





Focus Areas for Today's Report

Behavioral Health Services Department Budget Overview

Additional Updates Included in Appendices/Attachments:

- Appendix A - Behavioral Health Treatment Beds & Facilities Update
- Appendix B - Behavioral Health Services Act Updates
- Appendix C - BHSD Grant/Funding Stream Losses
- Appendix D - 988 and Mobile Crisis Updates and Data
- Attachment A - January 20, 2026 FGOC Report



Recent Reports related to Behavioral Health

1. Semi-Annual Report on Mental Health Diversion and the Collaborative Courts (November 13, 2025, PSJC)
2. Continuum of Services Across Diversion and Reentry Systems & AB 109 Funded Reentry Services (November 13, 2025, PSJC)
3. Appropriation Modification and Delegation of Authority for Psychiatric Emergency Response Team (November 18, 2025, BOS)
4. Salary Ordinance for Psychiatric Emergency Response Team (November 18, 2025, BOS)
5. Latino Health Action Plan Quarterly Report (November 20, 2025, CSFC)
6. Abode Rental Assistance Program Delegation of Authority (December 9, 2025, BOS)
7. Legislation Updates (December 9, 2025, BOS)
8. Notice of Intent to Purchase 264 N. Morrison Ave. (December 9, 2025, BOS)
9. Report from Multiple Departments Relating to the Status of Latino Health Assessment (December 9, 2025, BOS)
10. BHSD Facilities/Bed Expansion Updates (December 16, 2025, FGOC)
11. Measure A Expenditures and Revenues (December 16, 2025, FGOC)
12. BHSD Director's Report (December 16, 2025, HHC)
13. allcove Report (December 16, 2025, HHC)
14. Efforts to Increase Access to SUTS for Those in Custody and Transitioning Back to the Community (December 16, 2025, HHC)
15. Grant Activities for FY 2024-2025 (December 16, 2025, HHC)
16. Update on Implementation of Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (December 16, 2025, HHC)
17. Status Report on Behavioral Health Services Facilities on SCVMC Campus, including Inpatient Child and Adolescent Psychiatric Services (December 16, 2025, CSFC)
18. Purchase Agreement for 264 N. Morrison Ave. (January 13, 2026, BOS)
19. Donation from Valley Health Foundation for The Q Corner (January 13, 2026, BOS)
20. BHSD Facilities/Bed Expansion Updates (January 20, 2026, FGOC)
21. Behavioral Health Jail Diversion Programs (January 23, 2026, PSJC)
22. Approaches to Address Alcohol and/or Drug Abuse Needs for Female Clients (January 23, 2026, PSJC)
23. Countywide Efforts to Address and Prevent Homelessness (January 27, 2026, BOS)
24. Legislation Updates (January 27, 2026, BOS)
25. Inpatient Delegation of Authority Utilization Off-Agenda Report (February 3, 2026)



BHSD Budget Overview



Budget Overview Roadmap



- Role of Counties as Behavioral Health Plan (BHP) for Medi-Cal Beneficiaries
- Santa Clara County BHP Successes, Improvements, and Priorities
- FY 2026-2027 Financial Challenges
- FY 2026-2027 Budget Projections and Deficits
- Strategies for a Sustainable BHP
- BHSA Overview and Financial Impacts



Aurrera Health Group Presentation



- Aurrera Health Group (Aurrera) is a leading behavioral health financial and regulatory consultant for counties across California and the state.
- In addition to working with the Behavioral Health Services Department (BHSD) in its transition to California Advancing and Innovating Medi-Cal (CalAIM), Aurrera has also worked extensively throughout the state with numerous counties, advocacy groups, and providers.
- They are a leading expert in California behavioral health funding streams, regulations, and requirements.

About the Presenters

Aurrera Health Group is a mission driven health care consulting firm that works with counties, DHCS, and other organizations to improve access to comprehensive, high-quality health coverage and care.



Jill Donnelly, MPH

Managing Principal, Medicaid Programs



Devin McBrayer, MPH

Director, Behavioral Health Policy

Overview of the Santa Clara County Behavioral Health Plan

A life-saving safety net for the county's most vulnerable.

10,000 Foot View of County Behavioral Health

Santa Clara County is contracted with the California Department of Health Care Services to provide mental health and substance use disorder services to eligible Medi-Cal members



When a Medi-Cal member is experiencing a serious mental health illness or substance use disorder, counties must provide or arrange for the services that member needs



The county provides these services through a Behavioral Health Plan (BHP)

Mental Health Plan (MHP)

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

Who is eligible for county behavioral health services?

A provider evaluates an individual's illness or disorder, the severity, and determines what services that person needs. Severity informs whether the person needs services from the Managed Care Plan or the County Behavioral Health plan (*sometimes both*).

Managed Care Plans (e.g., Santa Clara Family Health Plan, Anthem)

Managed care plans provide mental health services to individuals with less intense mental health needs. These are sometimes referred to as mild-moderate mental health disorders.

Examples of Managed Care Plan mental health services include individual/group therapy, psychological testing, and outpatient psychiatric services to manage mental health medications.

County Behavioral Health Plans

County behavioral health plans serves individuals with severe or complex mental health or substance use disorders.

Individuals with severe or complex mental health needs are served through the Mental Health Plan.

Individuals with substance use disorders are served through the Drug Medi-Cal Organized Delivery System.

What Services Must County BHPs Provide?

Specialty Mental Health Services (SMHS) are provided through the **County Mental Health Plan (MHP)**:

- Specialty mental health services are specialized intensive mental health services for individuals with severe impairment resulting from a mental health disorder.
- Examples of services include, residential services, intensive care coordination, case management, therapeutic foster care, and crisis stabilization.

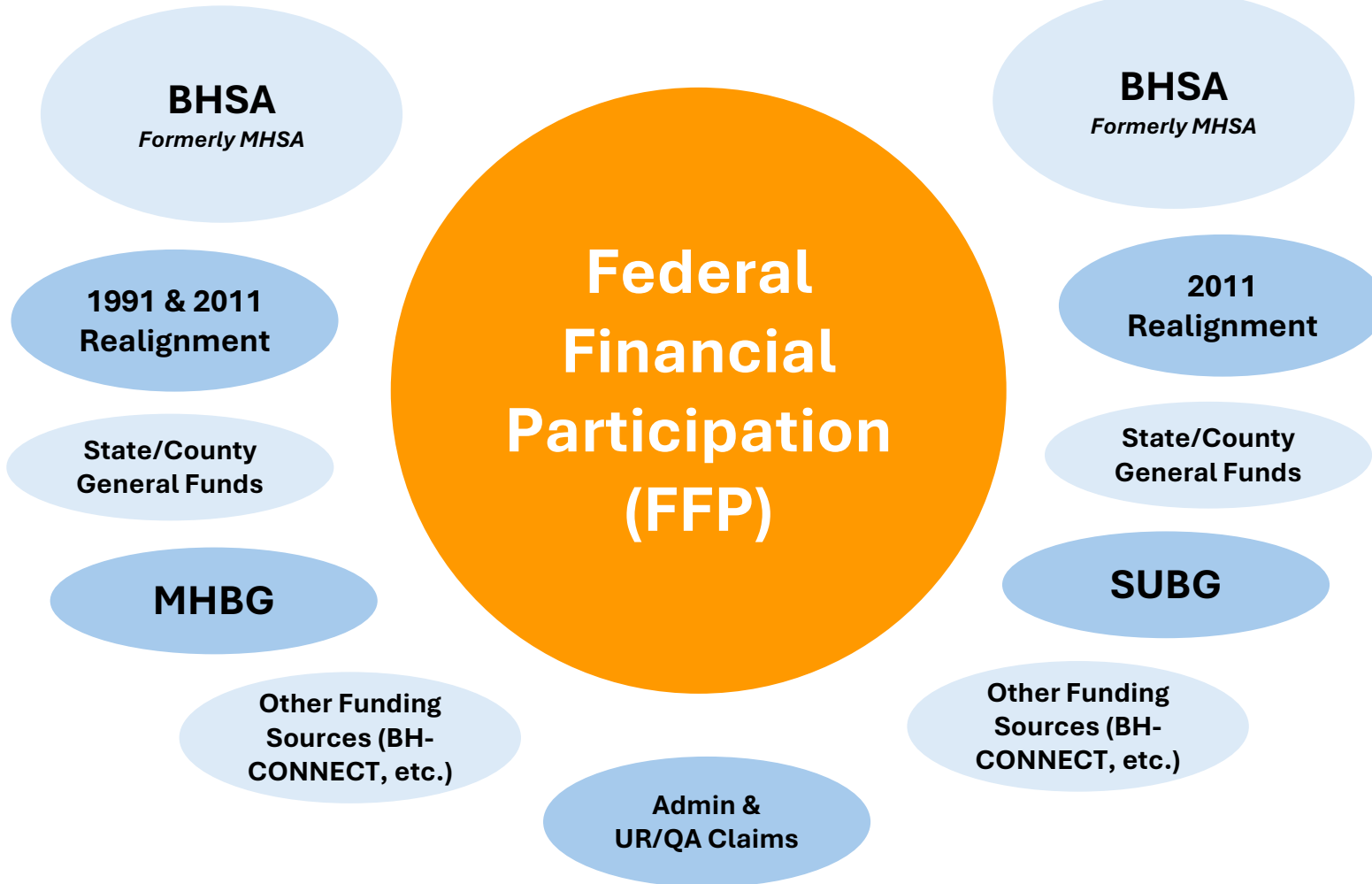
Substance Use Disorder (SUD) services are provided through the **Drug Medi-Cal Organized Delivery System (DMC-ODS)**:

- Substance use disorder services are for individuals addicted to substances such as opioids, alcohol, and meth.
- Examples of services include, crisis intervention, residential treatment, support through withdrawal, and Medications for Addiction Treatment (also referred to as MAT).

How County BHP Services are Funded

FFP: Federal Financial Participation
BHSA: Behavioral Health Services Act (formerly Mental Health Services Act)
MHBG: Mental Health Services Block Grant
SUBG: Substance Use Block Grant
BH-CONNECT: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
UR/QA: Utilization Review/Quality Assurance

Mental Health Services



SUD Services

Hierarchy of Requirements

Counties execute, but don't control the system.

Requirements for County BHPs

County BHPs are subject to requirements that are set by the federal government, the state negotiates aspects of the Medicaid program with the federal government, and then the state contracts with counties to provide those services.



Federal Government (CMS)

Sets Medicaid eligibility and coverage rules
Establishes financial, compliance, and quality requirements



State of California (DHCS)

Negotiates waivers with CMS to determine services provided and who is eligible for those services
The state then contracts with counties and sets rates and policies



Santa Clara County Behavioral Health

Delivers SMHS and DMC-ODS services or contracts with providers
Must comply with state and federal mandates (counties cannot opt in or out of core requirements)

Examples of State and Federal Requirements for County BHPs

Availability of services for eligible Medi-Cal members	Care coordination	Cultural competency	Documentation standards
Medi-Cal member rights and protections	Network adequacy	Performance Improvement Projects	Provider monitoring
Quality monitoring	Service utilization and penetration	Timely access to care	Workforce requirements

Fiscal Challenges and Compliance Risks

Making decisions in uncertain fiscal and political times.

Fiscal Challenges

Pressure on County BHPs to meet their federal and state mandates combined with an uncertain economy, means that there may be real limits on what the County BHPs can sustainably do above and beyond their federal and state mandates going forward

When County BHPs focus their efforts on the highest-need populations and align their spending with legal and contractual obligations, they can better manage compliance and fiscal risk

Changing Compliance Environment

- County BHPs are under increasing pressure to meet their federal and state mandates and at the same time, CMS scrutiny of DHCS is increasing
- These pressures continue to grow in today's political and regulatory climate—and they're not dependent on who is in federal or state office
- County BHPs will need to continue to focus on their core mandated services and align spending with the county's contracted responsibilities or risk facing consequences for not meeting their key mandates. Consequences of non-compliance for counties include:
 - Contractual consequences
 - Financial sanctions
 - Counties may face fines from DHCS as the state holds counties accountable to federal and state requirements. For example, in 2022 DMHC and DHCS fined LA Care \$55 million for failing to meet federal timely access to care requirements.
 - In 2025, DHCS sanctioned MCPs \$1.6 million for failing to meet minimum performance measures. DHCS issued BHPs corrective action plans in 2025 and DHCS has indicated that that fiscal enforcement will begin in future years for BHPs.
 - Increased oversight
 - Payment withholds

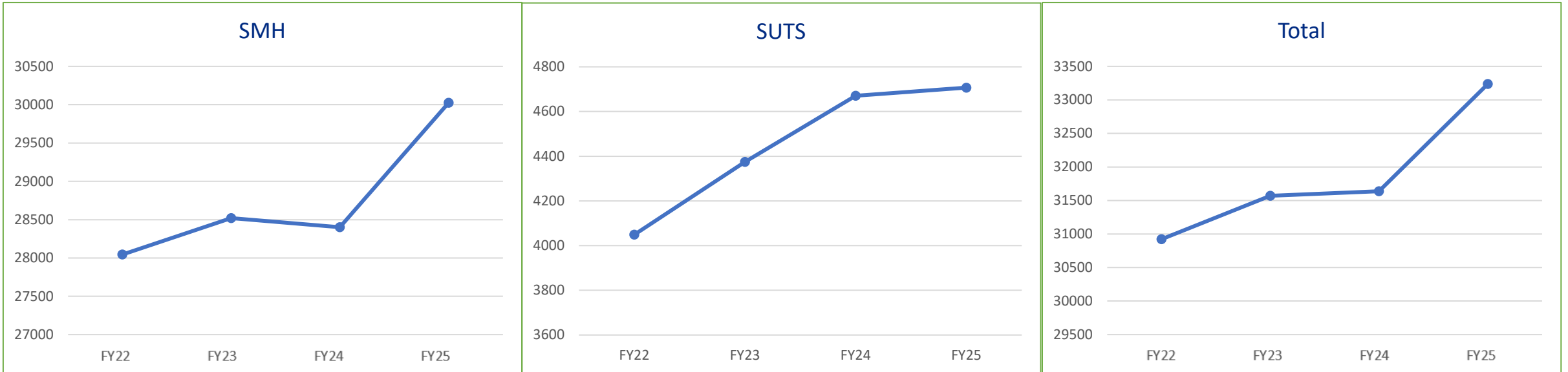
Mandated vs. Non-Mandated Programs

While BHSD provides a wide array of mandated and non-mandated programs, failure to provide mandated services would result in State fines, sanctions, and corrective action plans.

MANDATED PROGRAM CATEGORIES	NON-MANDATED
<p>Outpatient behavioral health services including the following specific programs:</p> <ul style="list-style-type: none"> • Clinic-based Outpatient Treatment (MH/SUD) • Peer Support Services (MH/SUD) • Early and Periodic Screening, Diagnostic, and Treatment (Under 21 years of age – U21) • Intensive Care Coordination (U21) • Intensive Home-Based Services (U21) • Therapeutic Behavioral Services (U21) • Therapeutic Foster Care • Medication Support Services (MH/SUD) • Day Rehabilitation (MH/SUD) • SUD residential treatment • Withdrawal Management <p>Intensive treatment Services for high-needs clients including:</p> <ul style="list-style-type: none"> • Day Treatment Intensive • Targeted Case Management Services • Full-Service Partnership (community-based comprehensive care services) • Assertive Community Treatment and Forensic Assertive Community Treatment <p>Crisis intervention and stabilization services including the following specific programs:</p> <ul style="list-style-type: none"> • Crisis Intervention • Crisis Stabilization • Crisis Residential Treatment • Community-based mobile crisis intervention services <p>Acute psychiatric treatment services:</p> <ul style="list-style-type: none"> • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Services (hospital-based) <p>Medi-Cal administrative activities BHSD must perform:</p> <ul style="list-style-type: none"> • 24/7 Call Center • Quality Assurance/Improvement • Concurrent Review and Utilization Management <p>Not mandated by Medi-Cal, but required uses for certain Federal and State funds</p> <ul style="list-style-type: none"> • Community Residential Placements • Housing services for beneficiaries experiencing or at risk of homelessness 	<ul style="list-style-type: none"> • Self-Help Centers (e.g., Zephyr and Esperanza) • Respite programs (temporary shelter that connects individuals to treatment and other services) • Workforce, Education, and Training (WET) projects and programs (e.g., intern programs, scholarship programs, grants for workforce development, county-sponsored trainings) • 988* • Outreach, engagement, and navigation services (helping individuals access services and understand their options) • Staff support for collaborative court operations (e.g., Court liaisons, assessors) • Prevention services (e.g., youth activities that prevent substance use, ad campaigns, psycho-education in schools and the community)* • Prevention & Early Intervention (PEI) programs (e.g., elder's storytelling, in-home respite, new refugee, early onset, wellness centers, promotores) • Drop-in centers (e.g., allcove, downtown youth wellness center) • School Linked Services program (generally not mandated, but \$8.7M of outpatient specialty mental health services within program are mandated out of an overall budget of \$18M) <p>* Primarily funded through grant funding</p>

- **Since July 1, 2022**, BHSD has **added a total of 263 behavioral health treatment beds** including **53 acute beds, 78 subacute beds, 81 mental health community residential beds**, and **51 substance use treatment services (SUTS) residential and withdrawal management beds**. The 263 behavioral health treatments beds can **serve an additional 2,850 clients per year**.
- **In FY 2024**, BHSD **exceeded State targets** in the following areas – a) **Adherence to antipsychotic medications** for schizophrenia; b) **Follow ups after hospitalizations for children** within 7 days; c) **Follow-ups after Emergency Department visits** within 7 days and 30 days for **clients ages 6+**; d) Use of first line psychosocial interventions for clients ages 1-17; and e) **Initiation and engagement** of alcohol/other drug use/or dependence treatment for **older adults**.
- **In FY 2025:**
 - BHSD funded **121 mental health clinics, 17 SUTS clinics, and 10 dual (mental health and SUTS) clinics** across its network of providers.
 - BHSD served **33,000** clients and many of the clients **achieved high success rates in their overall treatment goals. 76% of the SUTS clients met their clinical goals** and **67% of the mental health clients met their clinical goals**.
 - A total of **785,211 mental health outpatient hours** and **53,079 SUTS outpatient hours** were provided.
 - The BHSD Call Center received **20,621 calls for mental health services** and **17,599 calls for SUTS**. 988 Crisis and Suicide Prevention (CSPL) Lifeline received **60,128** calls, which resulted in **1,321 field visits**.
- **Advancing Access and Outcomes for the Latino Community**
 - **Latinos are the largest ethnic group (58% or 16,686 in FY 2025)** served by BHSD.
 - **BHSD providers are outperforming the statewide average among all counties** in providing access to mental health services to the Latino population.
 - **Latinos served by BHSD have good outcomes**. Latinos are equally likely to have successful treatment outcomes (**~70% program discharge rate**) compared to other racial/ethnic groups receiving mental health and SUTS from BHSD.
- BHSD provides mental health services to a higher percentage of the youth population than any other California county.
- BHSD is serving the **2nd highest percentage of all eligible adults with specialty mental health** services of any other large CA county.

Expanded Access to Specialty Mental Health and Substance Use Treatment Services - People Served

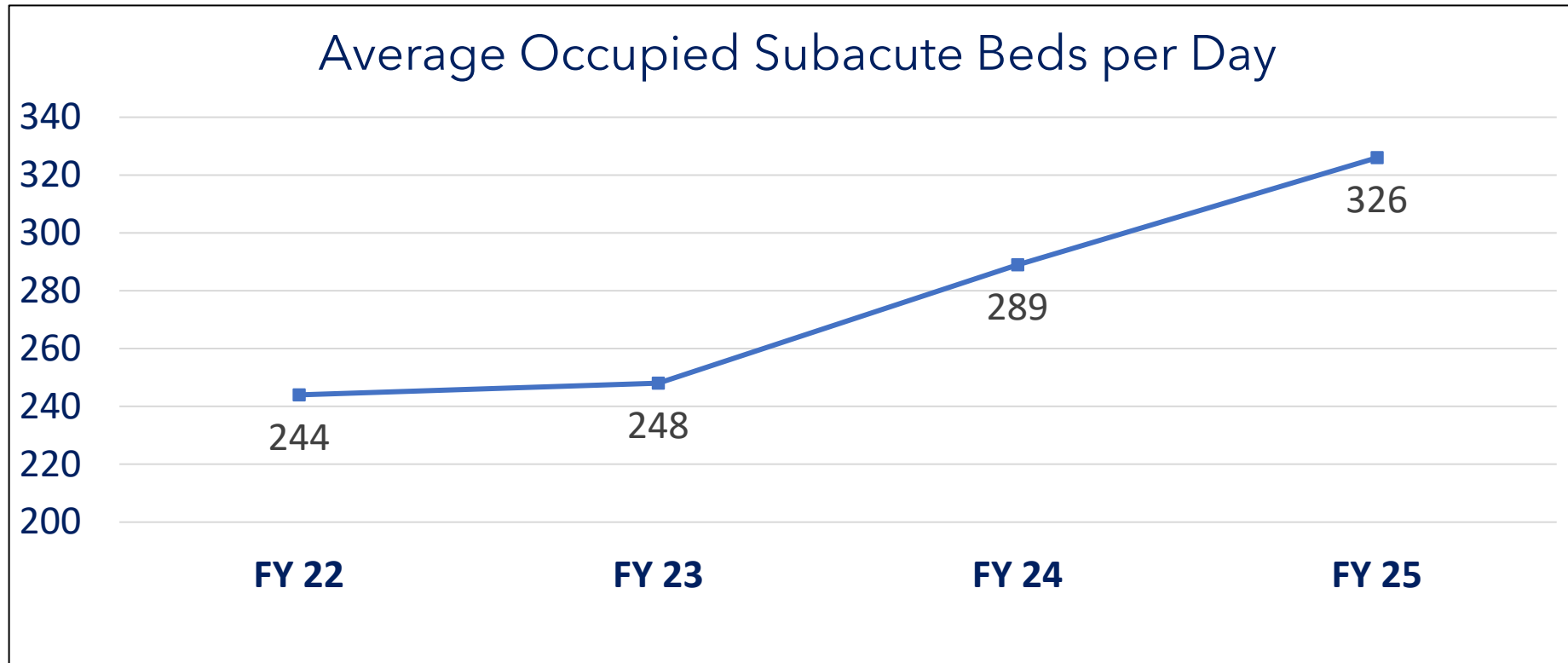


BHSD has seen an 8.2% increase in clients served in Specialty Mental Health (SMH) services since CalAIM.

BHSD has seen an 10.6% increase in clients served in Substance Use Treatment Services (SUTS) since CalAIM. BHSD anticipates a significant increase in SUTS clients served in FY 2026 as a result of the transition to Fee-For-Service.

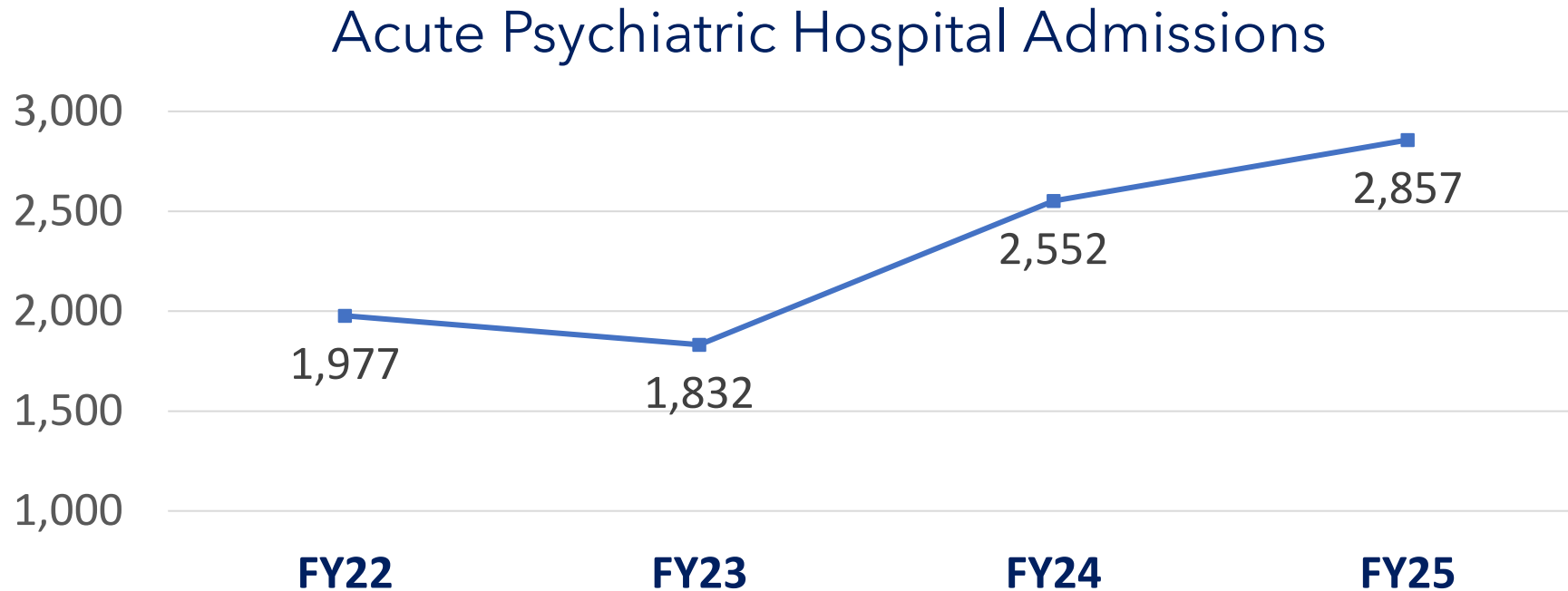
Overall clients served has increased 5.2% since CalAIM.

Subacute Expansions



The County has increased access to subacute beds by approximately 24% since 2022, resulting in a higher average daily census.

Increased Capacity to Meet Acute Treatment Needs



Acute admissions to psychiatric facilities have increased sharply in line with the inpatient bed expansions.

State Behavioral Health Reforms Impacting County Behavioral Health (2022-2025)

New Medi-Cal Benefits

- 24/7 Mobile Crisis Services (2024)
- 90-Day Jail In-Reach (2024-2026)
- Traditional Health Practices (2025)
- Peer Support Specialists (optional)
- Contingency Management (optional)
- BH-CONNECT Waiver Optional Benefits
 - Mental Health IMD
 - Peers with Forensic Specialty
 - Community Health Workers
 - First Episode Psychosis (BHSA required)
 - IPS Supported Employment (BHSA required)
 - Assertive Community Treatment (ACT) (BHSA required)
 - Forensic ACT (BHSA Required)
 - Community Transition In-Reach
 - Clubhouse Services

BH-CONNECT Waiver Required Benefits

- Multisystemic Therapy
- Functional Family Therapy Parent-Child Interaction
- High Fidelity Wraparound
- Evidence Based Practices (BHSA)
- Transitional Rent & Housing Trip (MCP provider & coordination)
- Enhanced Care Management
- Community Supports (option)

Program/Quality Reforms

- BH Payment Reform
- BH eligibility Criteria
- Mental Health & Substance Use Disorders (SUD) Plan Integration
- Documentation Reform
- BH Quality Incentive Program Comprehensive Quality Strategy

Behavioral Health Accountability Set

- Standardized Screening & Transition Tools
- Closed Loop Referrals
- No Wrong Door
- Current Procedural Terminology Coding
- Fiscal Reporting (BHSA)
- Outcomes Accountability (BHSA)
- Full Service Partnership (FSP) Levels of Care (BHSA)
- FSP Presumptive Eligibility
- SB 525 Minimum Wage
- Centers of Excellence
- Network Adequacy
- Cultural Competence Plan Reform
- National Committee for Quality Assurance Assessment/Incentive Pool
- Revised BHSA Community Planning Process
- SB 923 Transgender, Gender Diverse, Intersex Inclusive Care
- Opioid Settlement Funds

Children & Youth

- School-Linked Fee Schedule (Children & Youth Behavioral Health Initiative)
- Family First Prevention Services Act
- AB 2083 Children and Youth System of Care
- Office of Youth and Community Restoration
- Immediate Needs Program
- Tiered Rate Structure
- Child and Adolescent Needs and Strengths Alignment
- Mental Health Student Services Act
- BH-CONNECT Activity Stipends

Infrastructure (Treatment, Workforce, & Housing)

- Behavioral Health Continuum Infrastructure Program (BHCIP)
- Bond BHCIP (BHSA)
- Homekey+ (BHSA)
- No Place Like Home
- Community Care Expansion (CCE)
- Workforce Funding (BHSA)
- Workforce Funding (BH-CONNECT)
- Data Exchange

Parity

- Commercial Plan Contracting Requirement (BHSA)
- Commercial Plan Billing

Lanterman-Petris-Short (LPS) & Crisis Continuum

- SB 43 Grave Disability Criteria
 - Involuntary SUD
 - Necessary Medical Care
 - Personal Safety
- AB 2275 LPS Due Process
- AB 2242 LPS Discharge Coordination
- SB 929 LPS Reporting
- SB 1238 LPS Facilities
- 988 National Suicide Prevention Lifeline
- CARE Court
 - Cohort 1 (2023)
 - Cohort 2 (2024)
 - Expanded Reporting
 - Bipolar 1
 - SB 27 Referral Petitions

Housing/Homelessness

- BHSA Housing Category
- Behavioral Health Bridge Housing
- Transitional Rent

Department of State Hospitals

- Community Based Restoration
- Diversion
- Growth cap/Penalties

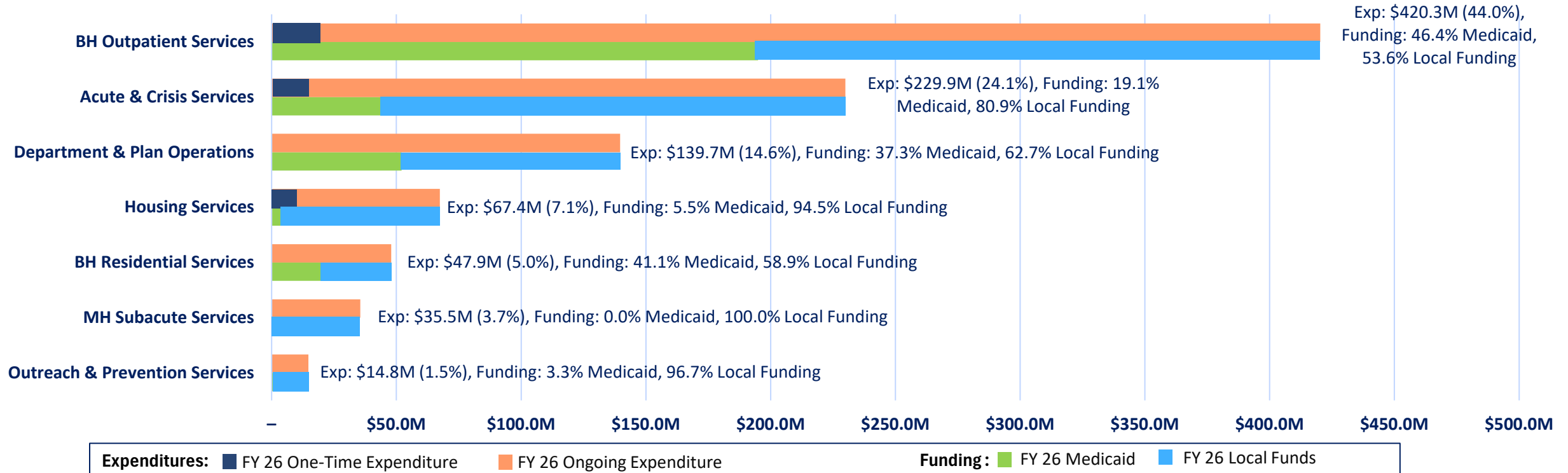
Voter Initiatives

- Proposition 36 Treatment Mandated Felonies
- Proposition 1 BHSA

BHSD FY 2026 Anticipated Spending and Medicaid Revenue

Referral: 10/21/25 Board Meeting (Item 17), Supervisor Arenas, Ellenberg, and Abe-Koga requested information on total BHSD budget and how deficits per funding stream compare to overall budget.

FY 2026 Anticipated Expenditure Budget by Service Category (\$956M)



Key Takeaways

1. Outpatient services represent BHSD's largest investment, totaling \$420.3M (44% of FY 2026 projected expenditures). While these services generate Medicaid revenue that covers 46.4% of total costs, they require 53.6% of costs to be covered by the County. Improving efficiency in this area is critical to preserve local resources for programs with limited Medi-Cal coverage.
2. Spending is highly concentrated in Outpatient (\$420.3M, 44%) and Acute & Crisis Services (\$229.9M, 24.1%), accounting for 68.1% of BHSD's total anticipated budgeted expenditures.
3. Department and Plan Operations are eligible for Medicaid reimbursement. BHSD will continue strengthening processes to maximize recovery through Medi-Cal Administrative Activities (MAA) and Quality Assurance & Utilization Review (QA/UR) activities.

Market Conditions

- Historical and structural underfunding of public behavioral health services with a corresponding lack of accountability for commercial insurers to provide these services to their members, leading to a fragmented healthcare system
- Increasing costs for behavioral health services (e.g., rate increases, CalAIM transition to Fee-For-Service, etc.)
- Shortage of affordable housing, supportive housing, and licensed residential care facilities for Medi-Cal beneficiaries
- Limited number of Medi-Cal providers
- Increasing reliance on county behavioral health systems by even those with private insurance
- Increasing demand – overall unduplicated clients served increases annually

Increasing Needs/Expenditures

- Voluminous and ever-changing legislation required funds and staffing to comply.
- Local declaration of a public health crisis by the Board of Supervisors in 2022 and Board-directed increased expenditures to expand programs, services, facilities, and beds.
- The start-up AND *ongoing* expenses of this expansion were covered by one-time fund balances and one-time MHPA allocations, creating reliance on fund balances to maintain service levels and support providers. Unfortunately, fund balances are nearly depleted, and countywide budget restricts available County funds to cover the shortfall.
- Increased expenses under CalAIM and post-declaration of public health crisis. Annual Medi-Cal service expense growth consistently exceeded 10%, peaking at 18% in FY 2024.

Current Fiscal Environment – Key Pressures

BHSD is operating in a challenging fiscal environment shaped by multiple external and structural factors. The following pressures are affecting funding stability, flexibility, and long-term planning.

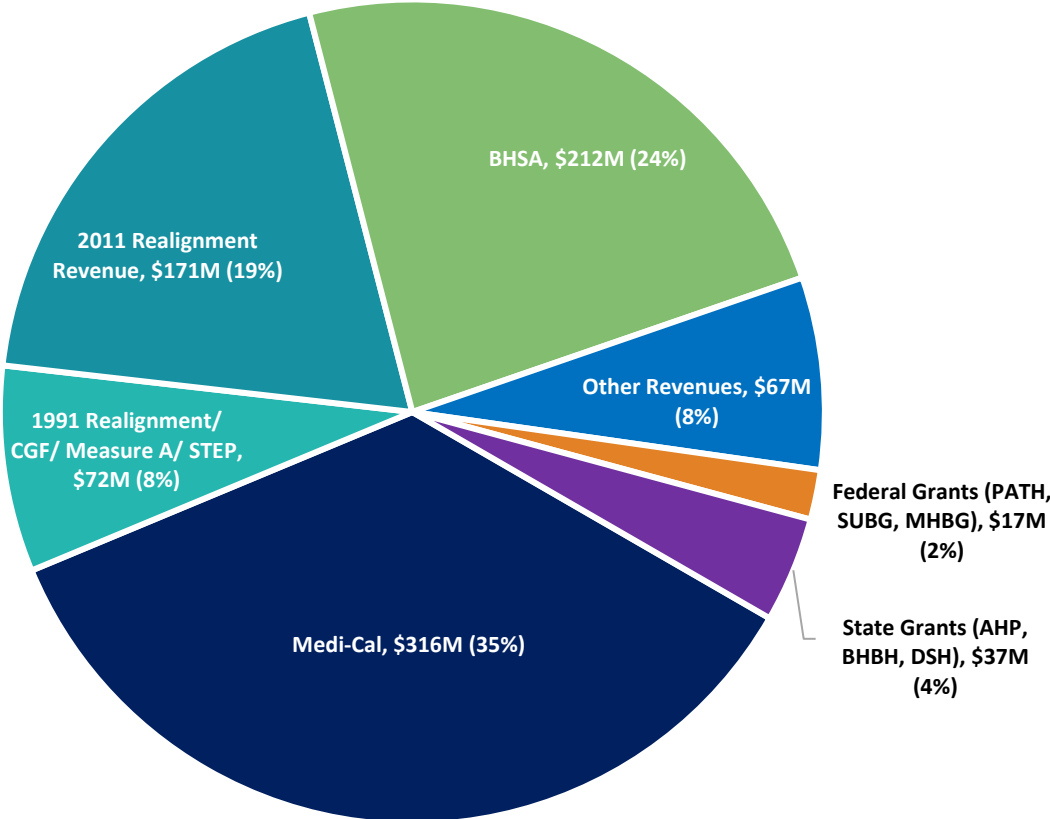
- Federal H.R. 1 includes changes that may affect Medi-Cal eligibility and reimbursement, creating uncertainty around future funding levels and increasing administrative workload.
- Behavioral Health Services Act (BHSA) changes include:
 - Redirect 5% of funding to the State
 - Dedicate 30% to specific housing programs, 35% to Full Service Partnership (FSP), and 35% of the remaining Behavioral Health Services and Supports (BHSS), reducing local flexibility in how funds can be used.
- Prior-year fund balances for BHSD funding sources will have been exhausted by the end of FY 2026, limiting the ability to rely on one-time savings to support ongoing services.
- Uncertainty around mobile crisis funding* makes it difficult to plan staffing and service levels for crisis response programs.
- Rising demand for behavioral health services continues to increase service volume and overall system costs.
- Improved billing and claims processing has increased reported expenditures as more services are captured for reimbursement.
- Significant increases in the number of criminal defendants found Incompetent to Stand Trial (IST) together with the Department of State Hospitals (DSH) pushing counties to provide more diversion services and reduce IST referrals resulting in more high-need clients receiving treatment in county behavioral health.

**Proposed change in Governor's budget (effective April 2027) would shift responsibility for the non-federal share of the benefit from the state to the counties at the same time that federal financial participation drops from 85% to 50%.*

BHSD FY 2026 Anticipated Funding Allocation

Referral: 10/21/25 Board Meeting (Item 17), Supervisor Arenas, Ellenberg, and Abe-Koga requested information on total BHSD budget and how deficits per funding stream compare to overall budget.

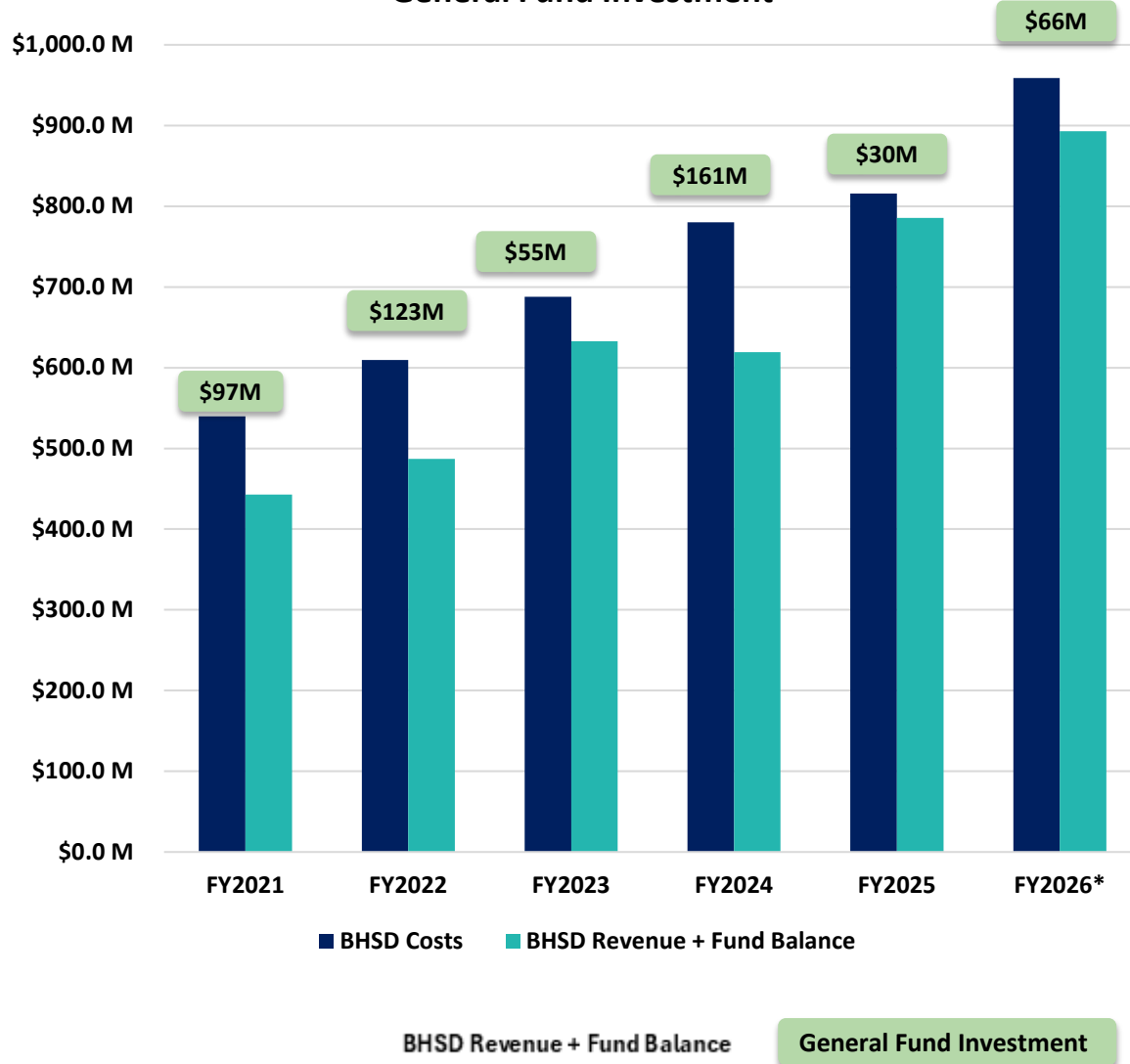
Total Anticipated Funding Availability (\$893.0M)



Key Takeaways

1. FY 2026 total anticipated expenditures (\$959M) exceed available funding (\$893M), indicating a structural funding gap of approximately \$66M that must be closed.
2. BHSD’s funding is heavily dependent on Medi-Cal (\$316M, 35%) and BSA (\$212M, 24%) which represents ~59% of total funding, increasing exposure to State and Federal policy changes.
3. Realignment funds remain critical, but are not growing nearly as fast as necessary to maintain current service levels.
4. BHSD expenditure will continue to grow as more behavioral health projects are added.

Year-over-Year Trends in Expenditures, Revenue, and General Fund Investment



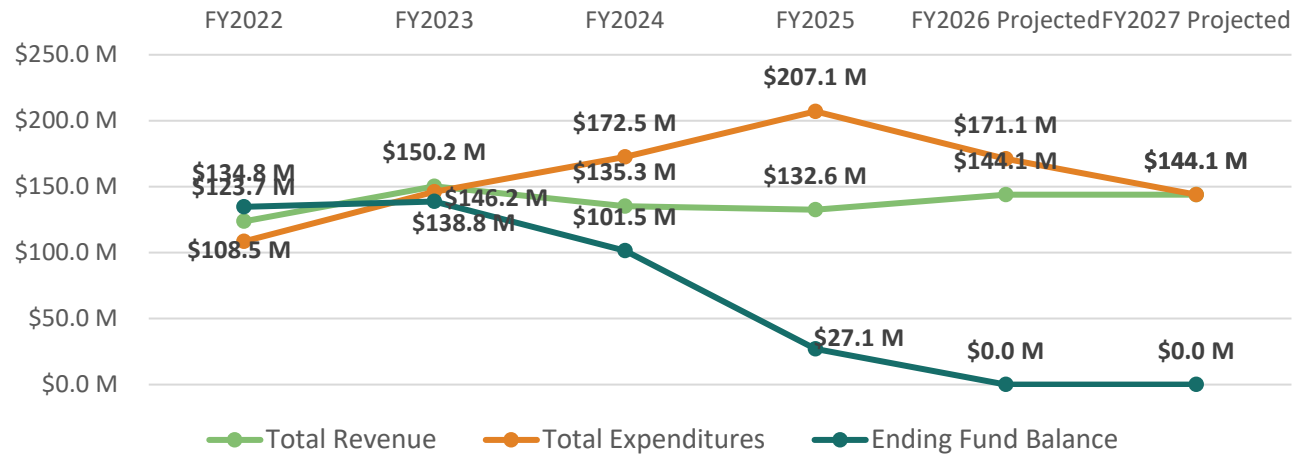
Key Drivers of the Current BHSD Financial Position

1. In FY 2022, the County declared a **Public Health Crisis** and responded by significantly expanding behavioral health services. BHSD expanded programs and service capacity, driving costs from **\$523.6M in FY 2020** to **\$958.7M in FY 2026**, an **83% increase**.
2. **Costs increased rapidly** due to the expansion of existing and new programs, increased service capacity, and the County providing financial support to County Contracted Providers (CCPs) so they could continue operating amid workforce shortages and rising expenses.
3. CalAIM modernized care and improved access, but it also shifted greater financial risk to the County when revenues did not increase at the same pace as expenditures.
4. In addition to service expansion, **annual rate structure increases** and cost-of-living adjustments (COLAs) have **significantly increased payments** to CCPs, contributing to substantial and ongoing growth in provider-related costs across the system.
5. To sustain services, BHSD relied on fund balance to cover gaps between costs and revenues; however, **by the end of FY 2026, fund balance will no longer be available** to support ongoing operations.
6. **Temporary revenue increases in FY 2024 and FY 2025** were driven by delayed Mental Health Services Act (MHSA) **one-time** payments related to COVID. Annual revenue will **normalize in FY 2026**, and Behavioral Health Services Act (BHSA) changes will **redirect an additional 5%** of County funding back to the State. MHSA/BHSA revenue is highly volatile and cannot be projected long-term.
7. As a result of the combined factors above, BHSD will require **new funding sources** or **cost reductions** to sustain moving forward.

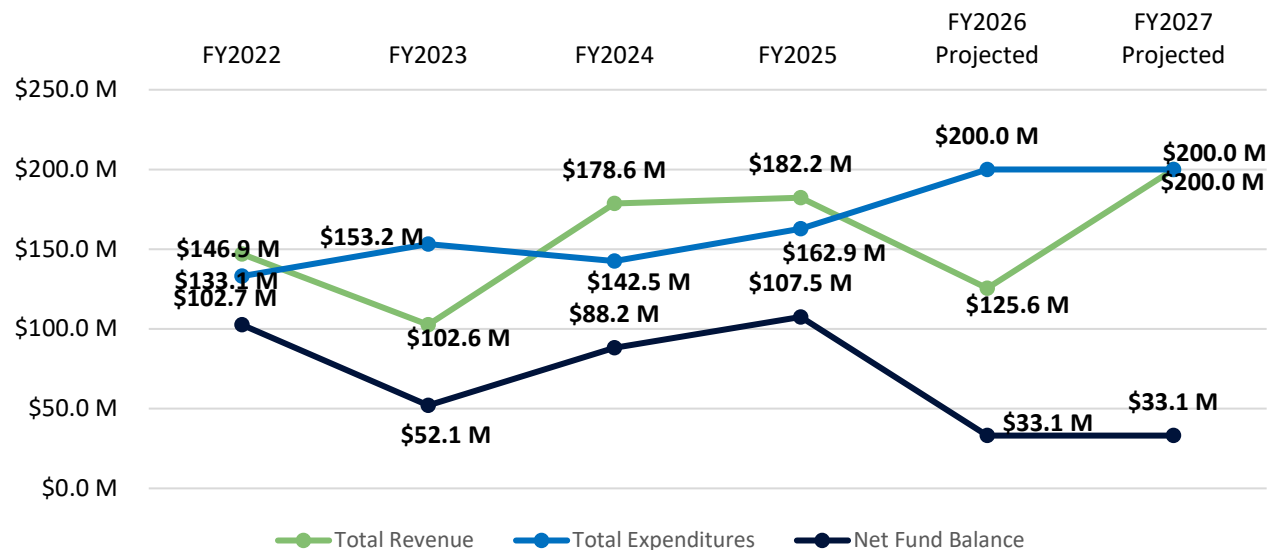
* Indicates years with **anticipated budgetary** costs and revenue

2011 Realignment and MHSA/BHSA

2011 Realignment Spend Trending



MHSA Spend Trending



Key Takeaways

1. BHSD's spending of 2011 Realignment funds has increased dramatically in the last 3 years.
2. The County's 2011 Realignment allocation from the state has been roughly flat because sales tax and fees have also been flat.
3. Fund balance was used to cover the difference between the annual allocation and annual spending.
4. If current spending and allocation trends continue, BHSD will run out of 2011 Realignment fund balance in the current fiscal year.
5. BHSD cannot have a negative fund balance and would need to reduce 2011 Realignment expenditure by \$27.1M by FY 2027, if no additional costs are incurred, or another funding source would be required to address the difference.

Key Takeaways

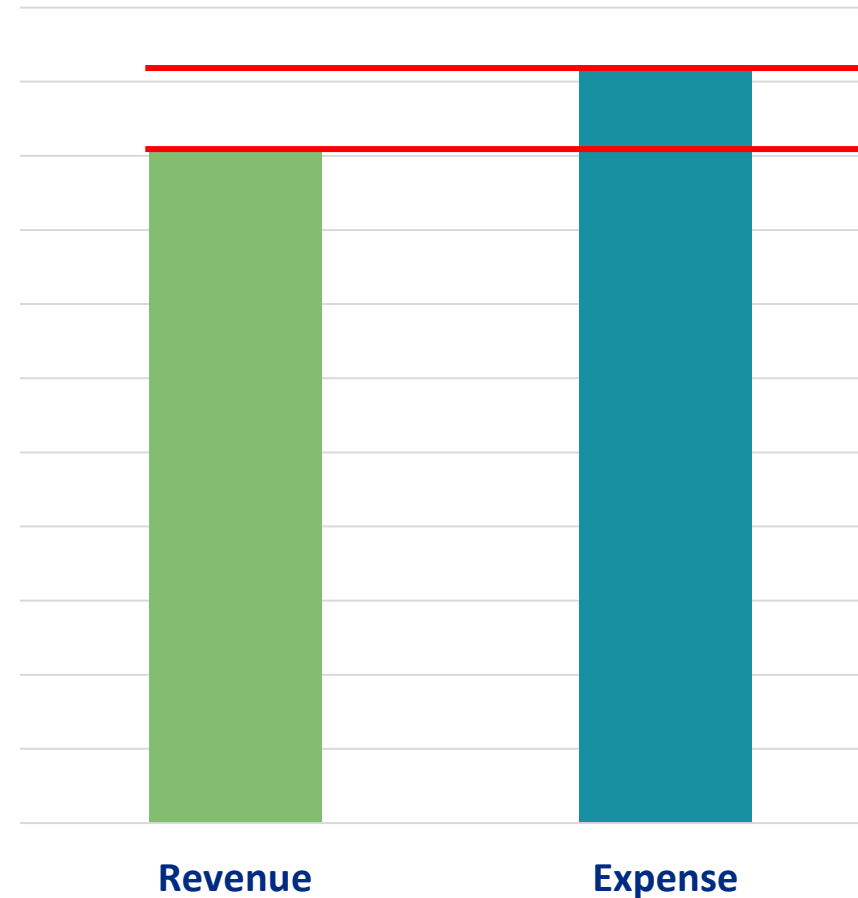
1. BHSD's spending of MHSA funds has increased overall since FY 2022 but is extremely volatile.
2. County's MHSA allocation from the State increased in FY 2024 and 2025 due to COVID-era adjustments. These one-time adjustments are not going to re-occur.
3. Spending increased in FY 2024 and 2025 because of increased revenues and goals set under the Declaration of a Public Health Crisis.
4. Funding ongoing expenditures with one-time funds resulted in an over-reliance on MHSA to cover the cost of treatment, programs, housing, and operations.
5. Based on a 5-year rolling average, BHSD is projected to receive \$190 million in FY2027. However, with the transition of MHSA to BHSA, there will be a one-time allocation of \$10 million included, bringing it to \$200 million.

FY 2026-2027 Deficit Projection

Factors Driving Projected Deficit

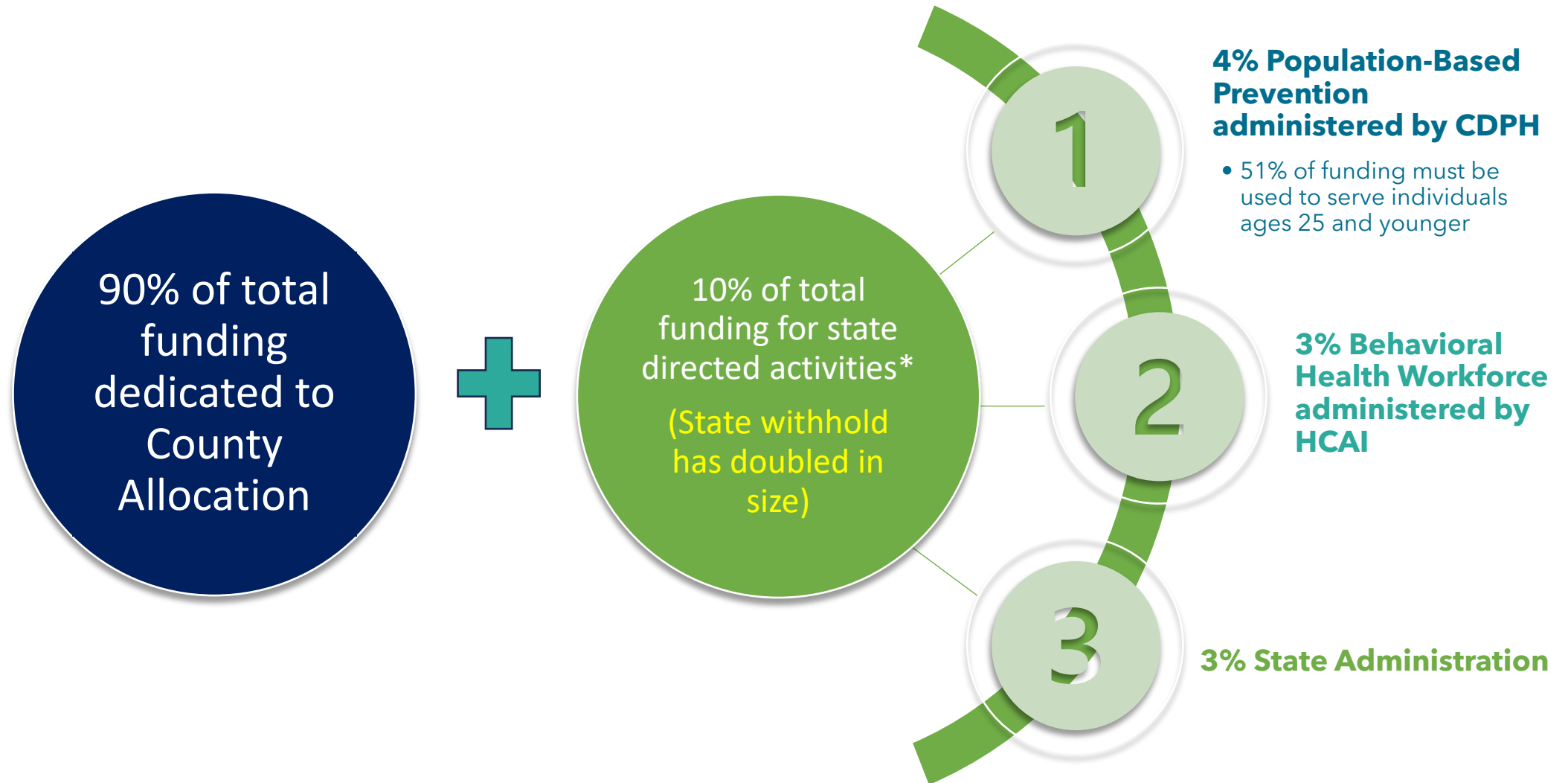
1. Reduced funding for current programs due to transition to BHSA.
2. Deletion of 2011 MH Realignment fund balances.
3. H.R. 1 impacts.
4. Increased utilization of services including subacute care which must be funded mostly with local funds.
5. Increased expenditures for new types of services required under Medi-Cal (e.g., eating disorder treatment, Transcranial Magnetic Stimulation) and priority programs (e.g., Enhanced Short-Term Residential Therapeutic Program).

\$1,100,000,000
\$1,000,000,000
\$900,000,000
\$800,000,000
\$700,000,000
\$600,000,000
\$500,000,000
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\$200,000,000
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Projected
\$100
million
deficit

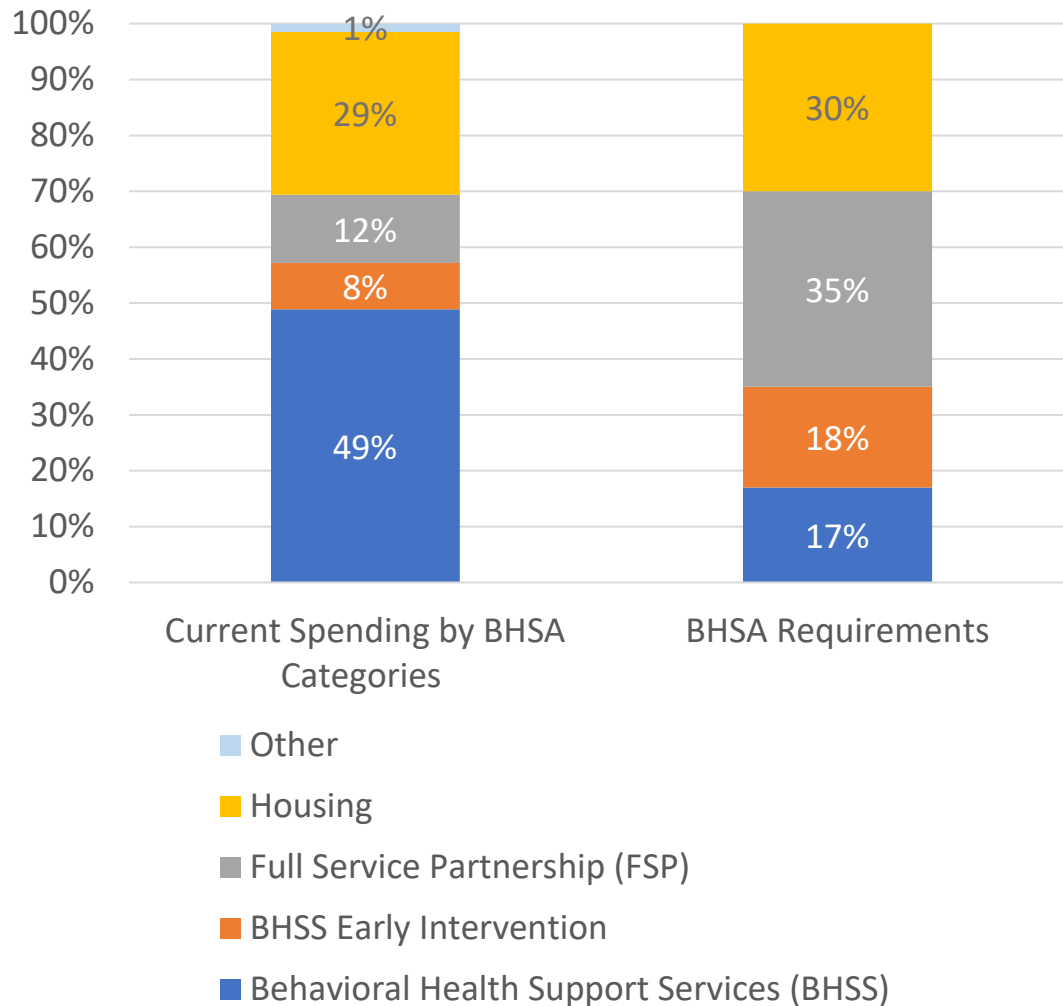
BHSA Overview of Changes: Funding Allocations



*Note: 10% of total funding is held by the state for state directed activities and not passed down to counties.

Allocation Transition from MHSA to BHSA

Allocation Transition from MHSA to BHSA



Key Takeaways

1. Under BHSA, the State will require County to increase spending to increase access to Full Service Partnership (FSP), Assertive Community Treatment (ACT), and Forensic Assertive Community Treatment (FACT).
2. Under the State methodology, BHSD estimates that we will be required to serve at least 10,000 more clients across various evidence-based practices including FSP, ACT/FACT, Individual Placement and Support (IPS), and First Episode Psychosis (FEP).
3. Some of those clients are currently in other lower levels of care, but we will use BHSD funds to pay for bundled rates and supplemental needs of those clients needing comprehensive case management and treatment services under the ACT/FACT or FSP models.

Referral: 10/21/25 Board Meeting (Item 17), Supervisor Arenas requested information on how County Contracted Provider (CCP) input was garnered to help mitigate the deficit.



- BHSD created an anonymous inbox active from Oct. 2025 through Dec. 2025 to collect deficit mitigation ideas from County staff. Nearly 100 suggestions were received, and an additional all staff meeting was held in Nov. 2025 to gather additional input.



- BHSD regularly met with members of the Behavioral Health Community Association (BHCA) throughout fall 2025 to share BHSD's budget outlook, answer questions, and discuss ideas for cost reductions and revenue increases.
- BHSD worked with a fiscal consultant to inform a rate adjustment that ensures cost recovery and long-term network sustainability.



- Requested provider ideas on program reductions and/or modifications that could achieve cost savings or revenue increases. Thus far, 2 of 34 CCPs have submitted their FY 2025 cost information. A total of 17 out of 34 CCPs submitted budget reduction ideas.



- BHSD executives met individually with all CCPs with cost-based (non-Medi-Cal leveraged) programs to discuss ways to evolve the programs leverage Medi-Cal or sunset programs as appropriate.
- BHSD continues to meet monthly with BHCA members to discuss budget updates and strategies and will convene smaller workgroups on specific topics throughout spring 2026.

Who Are We Talking About?



BHCA

Behavioral Health
Community Association
of Santa Clara County

Power in Partnership



BHCA Recommendations

- Re-Establish Step-Down Workgroup (IMD, Acute, EPS)
- Establish Private Insurance Billing Workgroup to Build System Capacity
- Capitalize on New Reimbursement Eligible Positions
- Track and Tightly Manage “Unsponsored” Funds
- Transition Appropriate Programs to Fee-for-Service
- Align Contract Amounts with Actual Service Delivery
- Remove Unmandated Staffing Requirements
- Reduce Duplicative Administrative Work
- Simplify Clinical Documentation Requirements

Financial Expectations



Continued Communication of Key Assumptions & Data Underlying Revenue Projections

- **State & Other Revenue:** BHSA; 1991 & 2011 Realignment; Medi-Cal County COLA; IMD FFP; SB 43 Reserve
- **Program Revenues:** Medicare (uncollected/expected); Private Insurance; Incentives
- **Fund Balances & Interest Earnings**

Consistent with direction from the Board of Supervisors' priorities, our guiding principles and strategies are as follows:

Guiding Principles

- **Ensure Access.** Beneficiary access is at the center of every recommendation and decision.
- **Preserve Core Services.** We will operate as a more efficient plan, prioritizing core services that are informed by evidence-based practices. Core services include the wide array of services required under the Medi-Cal specialty mental health and/or Drug Medi-Cal Organized Delivery System (DMC-ODS) benefits.
- **Advance Equity.** Decisions will be made through an equity lens.
- **Incorporate Stakeholder Feedback.** Decisions will be made with input from impacted groups.
- **Promote Transparency and Data-Driven Decisions.** Decisions will be informed by data and made with transparency.

Key Strategies & Priorities

- Return the County's behavioral health plan to financially sustainable path to ensure stability for the network and consistency for beneficiaries.
- **Maximize Medi-Cal leveraging** of available funding sources.
- **Ensure compliance** with State or Federal Requirements that have the potential to determine the survival of the County's Behavioral Health Plan.
- **Protect access** to core behavioral health services.
- **Maintain quality** of care and continue quality improvement.
- **Serve the most vulnerable beneficiaries** (e.g., dependent/justice-involved youth, beneficiaries experiencing institutionalization and/or incarceration due to behavioral health issues).

Revenue expansion strategies:

- Opt-in to all BH-CONNECT revenue opportunities
 - Incentive Program
 - Evidence-Based Practices (EBPs) and bundled rates
 - Institutions for Mental Disease Federal Financial Participation (IMD FFP)
- Medi-Cal Administrative Activities (MAA) (County and CCP)
- Quality Assurance (QA)/Utilization Reassurance (UR)
- Implement Enhanced Care Management (ECM) at County-operated sites
- Increase productivity across all network outpatient providers
- Accountability from managed care plans and commercial insurers

Cost-reduction strategies:

- Restructuring at all levels of BHSD to improve efficiency of operations
- Revenue cycle management improvements
- Cost-based programs transition to Fee-For-Service
- BHSD Forensic, Diversion & Reintegration (FDR) efficiency improvements
- Adapting the countywide mobile crisis response system to align with anticipated state benefit changes while ensuring sustainability.
- Focus on billing efficiencies within County-operated clinics including implementing AI software to improve productivity and accuracy in billing.
- Re-align contract payment rates with funding availability across all contract types.
- Ensure compliance with DHCS behavioral health managed care plan obligations to avoid corrective action plans and potential monetary sanctions.

Key Takeaways of BHSD Budget Overview

- BHSD has **large structural deficits** (spending exceeds funding) in two of its largest funding sources (i.e., BHSA and Realignment). These deficits resulted from a combination of State changes; increased spending from adding programs and beds; and higher rates for CCPs.
- In recent years, there have been **many new initiatives handed-down from the State to County behavioral health plans**. These new initiatives **did not come with new funding or adequate funding**.
- BHSD will need to **make reductions** in a way that **preserves the greatest degree of access to mandated services for the Medi-Cal beneficiaries** it is contracted to serve.
- The **State is not allocating additional funding for existing MHSA programs** with the transition to BHSA. Under BHSA, counties are required to increase spending on certain categories of activities (i.e., housing and Full-Service Partnership).
- Under BHSA, counties receive 90% of the fund allocation which should be utilized towards Housing, Full-Service Partnership (FSP) and Behavioral Health Services & Supports (BHSS). State withholding increases from 5% to 10%.
- BHSD is a noted **leader amongst large California counties** in adult and youth penetration rates for specialty mental health services, and **exceeded state performance targets** in: a) Engagement/initiation of treatment of SUTS for older adults; b) Use of first line psychosocial interventions for youth; c) Follow ups post-hospitalization for youth; d) Follow ups post-Emergency Department visits for youth and adults; and 3) Anti-psychotic medication adherence for schizophrenia.

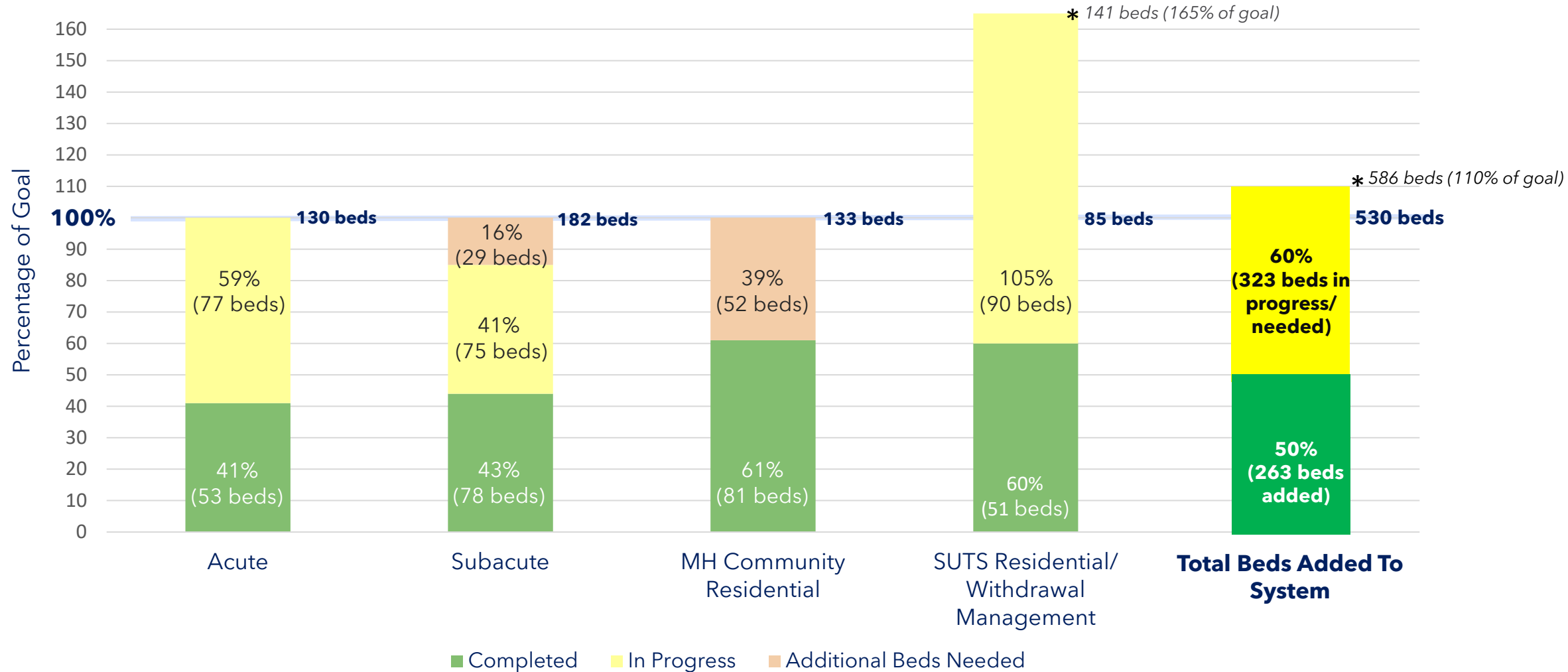




Appendices



Appendix A - Progress Towards Exceeding 530-bed Goal



* The SUTS Residential/Withdrawal Management level of care is on a path towards exceeding its original 85-bed goal by an additional 56 beds. This would result in the total number of beds to be added to the system increasing from 530 to 586.

Behavioral Health Treatment Beds & Facilities Progress

Goal: By 2030, BHSD aims to exceed its goal of increasing behavioral health treatment beds 50% by adding approximately 530 beds to the system of care

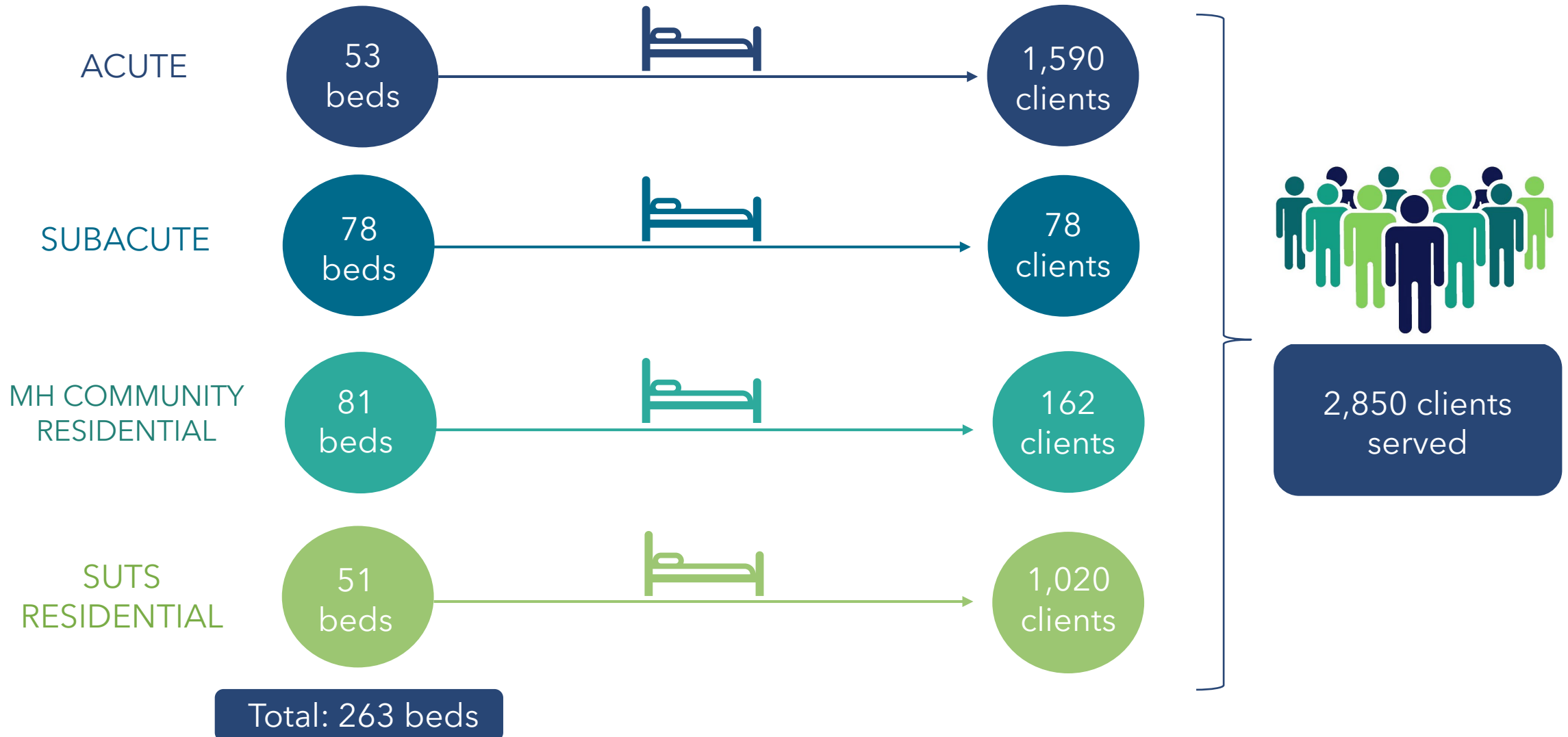
Level of Care	Baseline Prior to 7/1/22	Interim Goal for Additional Beds	Beds Added Since 7/1/22	Beds from Projects in Process	Additional Beds Needed to Meet Interim Goal	Future Total Beds (Baseline + Interim Goal)
Acute	321	130	53	77	0	451
Subacute	253	182	78*	75	29*	435
MH Community Residential	309	133	81	0	52	442
SUTS Residential (and Withdrawal Management)	177	141	51	90	0	318
TOTAL	1,060	Exceeding 530 bed goal by 56 beds (586 total)	263*	242	81*	1,646

**Since the November 4, 2025 quarterly report, a total of 3 additional subacute beds were accessed.*

Table does not include 294 Recovery Residences funded by BHSD as temporary housing for clients with SUD.

Number of Clients Served Annually by Added Beds

Goal: By 2030, BHSD aims to exceed its goal of increasing behavioral health treatment beds 50% by adding approximately 530 beds to the system of care



Appendix B – Behavioral Health Services Act (BHSA) Updates

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition.

Integrated Plan (IP) Document

Replaces the MHSA 3-Year Program & Expenditure Plan

First IP submission to DHCS by June 30, 2026 (IP Portal)

Annual Updates for 2nd and 3rd year of the IP period

Intermittent updates can be submitted at any time during 3-year IP cycle

Global Spending Plan

Report all planned activities (including SUD services) and projected expenditures for BHSD's services regardless of funding source

Includes BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, local and other funding

Behavioral Health Goals & Measures

Integrates statewide behavioral health goals and population-level behavioral health measures

Incorporates health equity in each of the behavioral health goals

Behavioral Health Transformation Timeline*

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition including upcoming deadlines.

January 2025 - June 30, 2026

- Preparing for the transition from MHSA to BHSA
- Engaging stakeholders in new Integrated Planning Process
- March 31: First Draft of 3-Year County Integrated Plan due to DHCS

Spring 2026

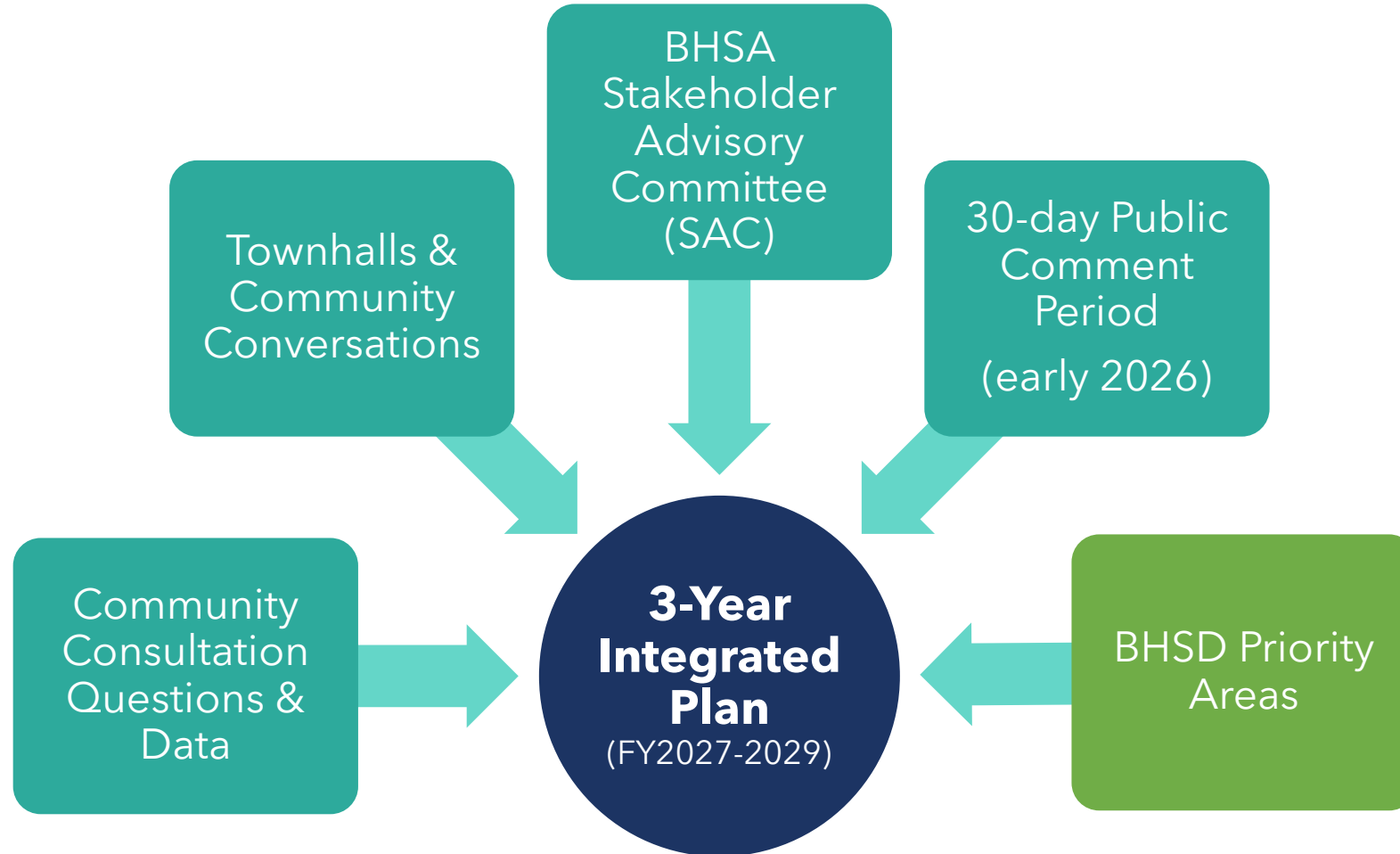
- April 2026: BHSA Integrated Plan 30-Day Public Comment Period
- April 2026: BHSD Budget Proposal goes to Committees
- May 2026: Budget Workshops
- June 2026: Budget Sessions

June 30, 2026

- Final 3-Year County Integrated Plan due
- BHSA takes effect on July 1, 2026

BHSA Community Planning Process

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition, including stakeholder recommendations.



BHSD has actively been engaging the community and Stakeholder Advisory Committee in its BHSA planning process and will be considering stakeholder priorities into the first Integrated Plan.

- Children, Youth & Families
- Housing
- Justice-Involved
- Under-Resourced Communities
- Substance Use Treatment Services

BHSA Stakeholder Engagement Timeline

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition including deadlines and stakeholder recommendations.



MHSA → BHSA Preparation

Winter 2024

- DHCS Stakeholder Engagement sessions began.
- MHSA SLC Subcommittee discussions began on restructuring under BHSA.
- Invited local stakeholders from diverse viewpoints to apply for BHSA Stakeholder Advisory Committee (SAC)

Previous Community Planning Process under MHSA



Community Planning Process

January to August 2025

- Reviewed current BHSD programs and used statewide and local data to guide stakeholder community outreach.
- Engages constituents and stakeholders for community input via townhalls, community conversations, and community consultation groups.
- Established BHSD priority focus areas, based on county data and findings to create community consultation questions.

Current Community Planning Process under BHSA



Stakeholder Advisory Committee

September 2025

- Appointed first cohort under BHSA SAC with 11 members. SAC consists of an equitable distribution of consumers, family members, and providers.
- Developed SAC Subcommittee structure. Subcommittee serve as a bridge between the community and SAC.
- More info. on SAC membership: [Click Here](#)



Identifying County Priorities

October 2025 - Present

- SAC reviewed data, community feedback, and advised on recommendations around the priority areas for BHSD.
- BHSD Leadership is reviewing SAC feedback and evaluating recommendations for the BHSA Integrated Plan.

5 Stakeholder Advisory Committee Focus Areas

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition, including stakeholder recommendations.



- **Children, Youth & Families** including Early Intervention & Youth Crisis Services



- **Substance Use Treatment Services** including focus on older adults & under-resourced groups



- **Under-Resourced Communities** including culturally specific services



- **Justice-Involved Services** including resource-linked programming



- **Housing-Related Services** including the expansion of housing-behavioral health treatment programs

Exceeding Minimum Spending Requirements on Housing and BHSS

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a detailed report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition, including areas of potential impact.

- Exceeding minimum spending requirements on Housing & Behavioral Health Services and Supports (BHSS) categories
 - BHSS including County-operated outpatient clinics & program staffing
- Several cost-based programs funded with MHSa PEI will transition to fee-for-service Medi-Cal services or sunset.
- Proposed reductions will be provided during the FY 2026-2027 Budget Process (April Health & Hospital Committee, May Budget Workshops and June Budget Sessions).



Future of Innovation (INN) Projects

Referral: 3/25/25 Budget Hearing (Item 13) and 6/17/25 (Item 15), Supervisor Ellenberg requested a detailed report on the Behavioral Health Services Act (BHSA) budget in preparation for the transition including updates on Innovation Projects.

- No dedicated INN funds under BHSA.
- Current state-approved MHSA funded Innovation projects will continue.

INN Project	Key Dates
INN 15 – Trusted Response Urgent Support Team (TRUST)	<ul style="list-style-type: none"> • Project ends under INN in November 2026 & services will continue under BHSA and Medi-Cal Mobile Crisis Benefit
INN 17 – Transgender, Non-Binary & Gender Expansive (TGE) Center	<ul style="list-style-type: none"> • Project will commence in early 2026
Program Improvements for Valued Outpatient Treatment (PIVOT) - An INN project designed to assist counties in the transition to BHSA from MHSA. Santa Clara County will utilize unspent INN funds from previously approved INN projects to support 3 key areas identified in the PIVOT project: 1) FSP Reboot; 2) Capacity Building for Diverse Communities; and 3) Workforce	<ul style="list-style-type: none"> • Project will commence in spring 2026

Appendix C - Time-Limited Grants/Funding Streams

Referral: 1/23/26 PSJC Meeting (Item 8): Supervisor Ellenberg requested a consolidated list of grants/funding streams BHSD has lost currently and in the future fiscal year.

FY 2025-2026 - Grant/Funding Stream	Reason for Limited Time Funding	End Date
Children & Youth Behavioral Health Initiative (CYBHI) (Round 1 & 3)	State provided a fixed, one-time allocation to support the initial launch and early implementation of CYBHI programs.	6/30/2026
Community Assistance, Recovery, and Empowerment (CARE) Act Start-Up Funds	One-time State funding to support initial staffing, systems, and service expansion required to implement CARE Act requirements.	6/30/2026

Future Fiscal Years - Grant/Funding Stream	Reason for Limited Time Funding	End Date
Behavioral Health Bridge Housing	One-time State allocation distributed by formula.	6/30/2027
Byrne State Crisis Intervention Program	Time-limited federal grant awarded to the Superior Court, with BHSD providing services through a Memorandum of Understanding agreement.	Round 1- 8/31/26; Round 2- 6/30/27
Community Care Expansion Capital Project	A one-time grant from the State, administered by counties, to help preserve capacity in licensed residential care facilities.	12/31/2026
Proposition 47	Competitive grant funding subject to periodic application and award cycles; most recent application was not awarded.	12/31/26
Department of State Hospitals Incompetent to Stand Trial Diversion	5-year grant with potential renewal, subject to continued State budget inclusion.	FY 2029

- Note: County is closely monitoring federal actions that could target Substance Abuse and Mental Health Services Administration (SAMHSA) block grants (i.e., Substance Use Block Grant and Mental Health Block Grant). The Governor's budget includes changes to the mobile crisis benefit that would reduce the state's contribution to these services, although the federal Medicaid contribution would remain the same. County also projects reductions in Medicaid revenue due to H.R. 1.

Appendix D - Crisis Support and Mobile Response Programs

Referral: 8/26/25 Board Meeting (Item 13): Supervisor Ellenberg requested that the average call wait time for 988 and TRUST continue to be included in BHSD quarterly reports.

Calls to 988/CSPL total to ~4,981 per month with 92.6% of those calls going directly to and are handled telephonically by 988/CSPL. The remaining 7.4% are transferred or made directly to TRUST (3.6%), MRSS (0.6%), MCRT (3.2%), or 911 that may be referred to PERT (0.001%). 988/CSPL Call Center's average wait time is about 12.7 seconds.

Calls Made or Transferred to Mobile Crisis Teams (October 2025- December 2025)

Program	Calls	Average Field Response Times	Age of Clients	Peak Times & Days	Field Visit Disposition
TRUST	Total Calls: 1,728 <ul style="list-style-type: none"> Resulting in Clinical Consult: 37 Resulting in Field Visit: 1,076 	31 min — Average Call Wait Time: 0 min	<ul style="list-style-type: none"> 16-25: 22% 25-59: 62% 60+: 16% 	4pm-11:59pm (M, T, W)	<ul style="list-style-type: none"> Stabilized and/or linked to resources: 55% 5150/5585 Hold: <1% Canceled/Decline: 43% (Most common reasons for canceled/decline voluntary TRUST services include- 1) inability to locate individual, 2) a community member calls about an individual, but the individual turns down voluntary services when TRUST engages them, or 3) referred to MCRT) EMS activated/Medical Clearance: 2% LEA Arrest: <1%
MRSS	Total Calls: 845 <ul style="list-style-type: none"> Resulting in Clinical Consult: 497 Resulting in Field Visit: 497 	31 min	<ul style="list-style-type: none"> 1-15: 69% 16-25: 31% 	8am-2pm (M, T, W, Th)	<ul style="list-style-type: none"> Stabilized and/or linked to resources: 52% 5150/5585 Hold: 22% Canceled/Decline: 26% (Most common reasons for canceled/decline voluntary MRSS services include- 1) individual and/or family could not be located or 2) the individual and/or family turns down voluntary services when MRSS engages with them. EMS activated/Medical Clearance: 0% LEA Arrest: 0%
MCRT	Total Calls: 638 <ul style="list-style-type: none"> Resulting in Clinical Consult: 64 Resulting in Field Visit: 307 Calls Directly from LEAs: 107 Calls Directly from LEAs Requiring Field Visit: 51 	34 min	<ul style="list-style-type: none"> 1-15: 5% 16-25: 18% 26-59: 62% 60+: 15% 	12pm-4pm (M-F)	<ul style="list-style-type: none"> Stabilized and/or linked to resources: 44% 5150/5585 Hold: 49% Canceled/Decline: 4% (Most common reasons for canceled/decline voluntary MCRT services include- 1) individual and/or family could not be located or 2) the individual and/or family turns down voluntary services when MCRT engages with them. EMS activated/Medical Clearance: 2% LEA Arrest: 1%
PERT*	Total Calls: 152 <ul style="list-style-type: none"> Resulting in Clinical Consult: 66 Resulting in Field Visit: 86 	8 min	<ul style="list-style-type: none"> 1-15: 7% 16-25: 11% 26-59: 62% 60+: 20% 	12pm-5pm (T-Th)	<ul style="list-style-type: none"> Stabilized and/or linked to resources: 66% 5150/5585 Hold: 7% Canceled/Declined: 12% (Most common reasons for canceled/decline voluntary PERT services include- 1) individual and/or family could not be located or 2) the individual and/or family turns down voluntary services when PERT engages with them. EMS activated/Medical Clearance: 13% LEA Arrest: 2%

*PERT is dispatched by 911 call centers

Referral: 11/18/25 Board meeting (Item 36), Supervisor Abe-Koga requested check-in on the transition from PERT to MCRT. Supervisor Arenas requested data on number of individuals in custody who have had a documented psychiatric crisis.

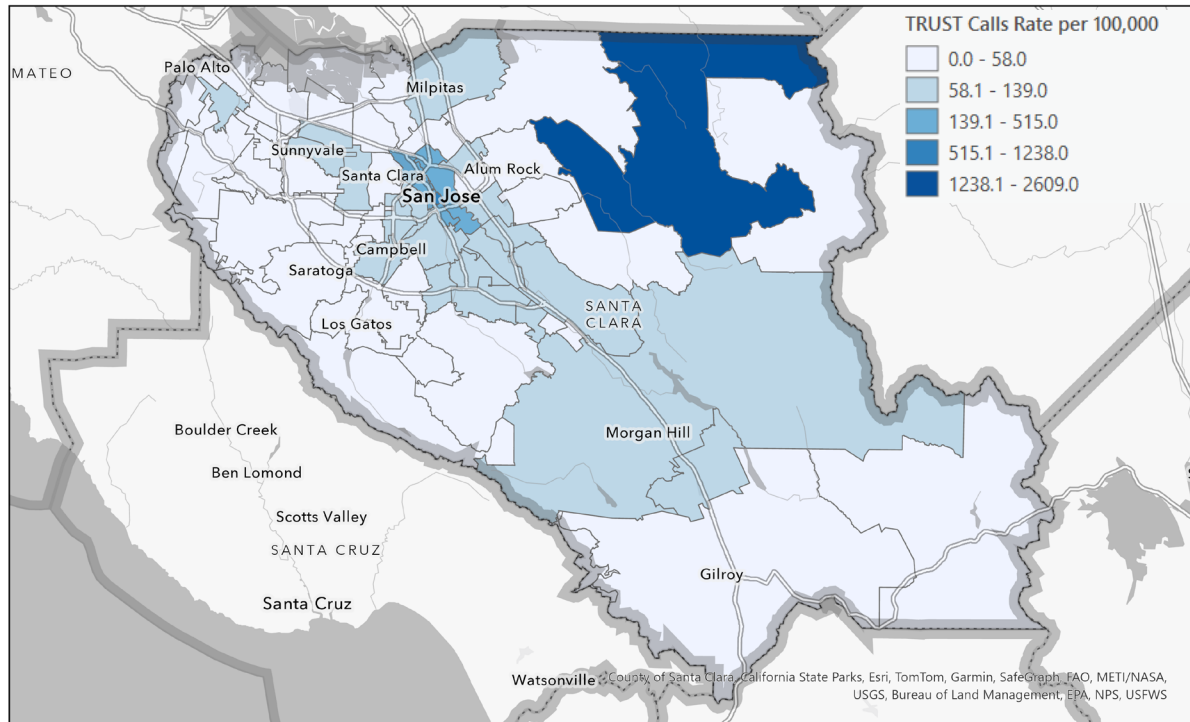
- **MCRT Update Post-PERT**

- Between Oct 3, 2025 to January 16, 2026, MCRT received 82 calls directly from law enforcement agencies (LEAs) through the backline created for LEAs to reach MCRT directly. Of the 82 calls, 12 were triaged over the phone by MCRT staff, 24 required MCRT to co-respond in the field with LEAs, and 46 calls were test calls made by MCRT and LEAs to ensure functionality and appropriate access to the backline. BHSD continues to collaborate with LEAs, meeting them at the end of January 2026 for feedback and adjustments as needed and will continue to check-in with LEAs quarterly.

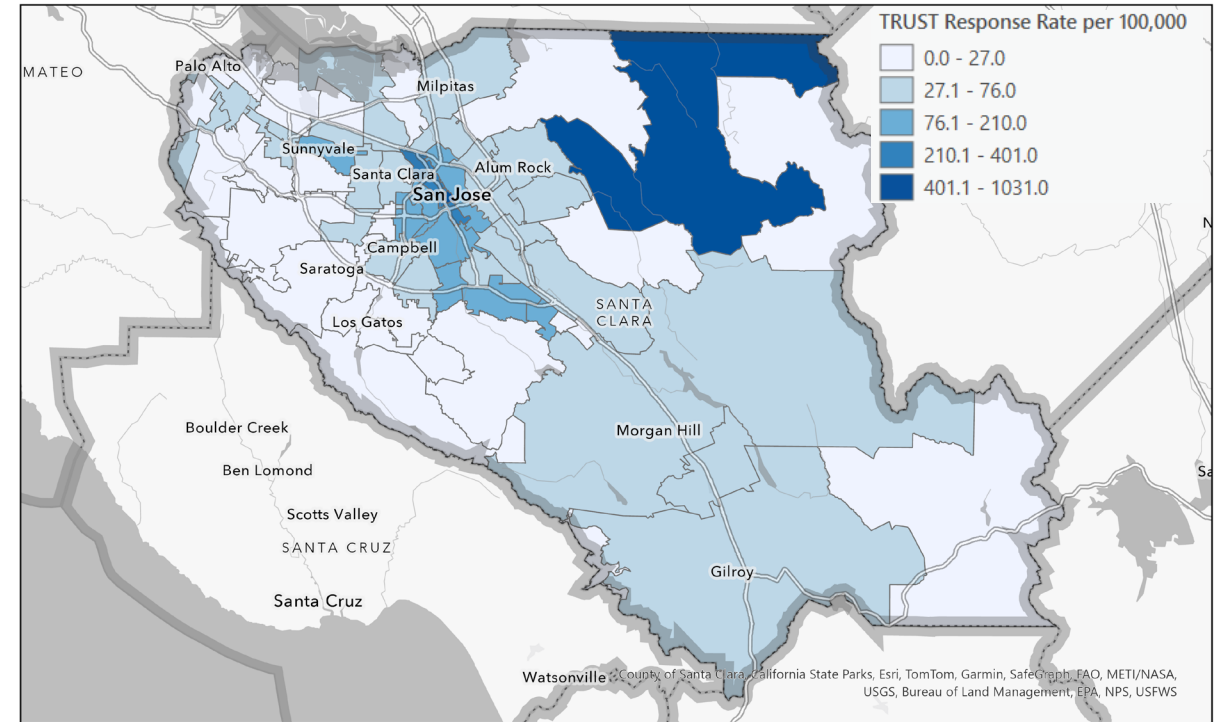
- **Number of Individuals with Documented Psychiatric Crisis in Custody – estimated 1,637 adults**

- Limited or incomplete data is available to help understand the number of adult individuals experiencing psychiatric crisis in the community prior to or during their arrest.
- The following Calendar Year 2025 data helps provide some estimates:
 - **Agency Advisory Form (AAF):** An arresting officer has indicated that an individual was demonstrating suicidal behavior- **298 unduplicated adults (310 arrests)**, and/or behaving as a Danger To Self (DTS), Danger To Others (DTO), or Gravely Disabled - **225 unduplicated adults (231 arrests)**
 - **Acute Psychiatric Unit (APU) Main Jail:** Booked into jail and transferred directly to the APU - **833 unduplicated adults (1,104 arrests)**
 - **Emergency Psychiatric Services (EPS Valley Medical Center):** Adults assessed at booking and transferred to EPS who were cited and released based on a Welfare and Institutions Code (WIC) 5150 - **281 unduplicated adults (312 arrests)**
- These numbers are estimated because they rely on 1) the accuracy of the AAF and 2) self-report of individuals who were arrested after experiencing a psychiatric crisis, but who are missed in the AAF form or do not meet the conditions for APU or EPS admission.

Calls Referred to TRUST



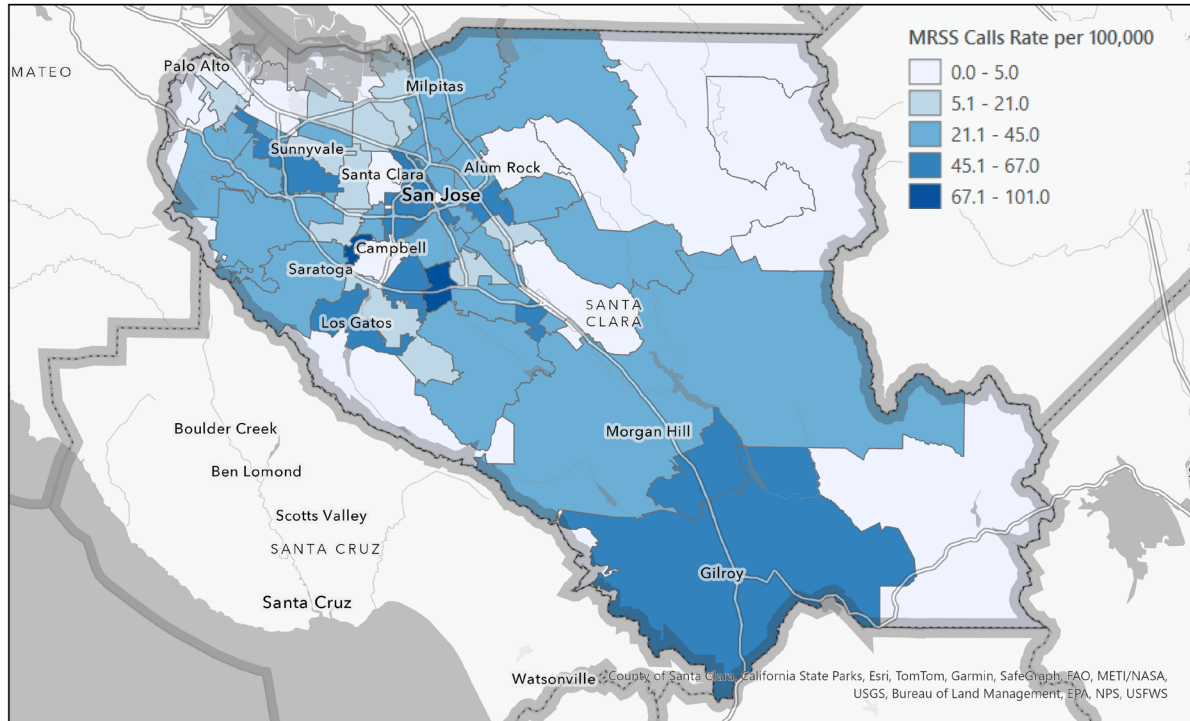
Calls Requiring a Field Visit



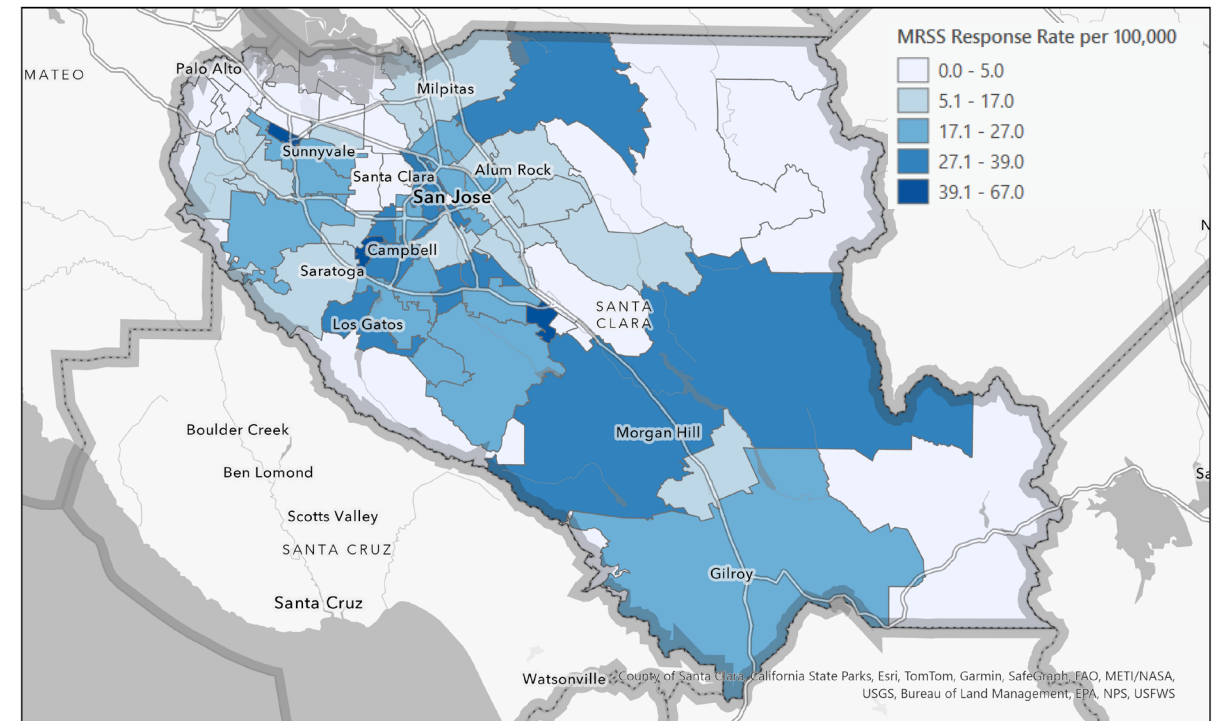
Zip code 95112 (San José) had the most TRUST activity, with 161 calls (resulting in 128 field visits), followed by 95110 (San José) with 104 calls (resulting in 81 field visits).

MRSS Heat Maps

Calls Referred to MRSS



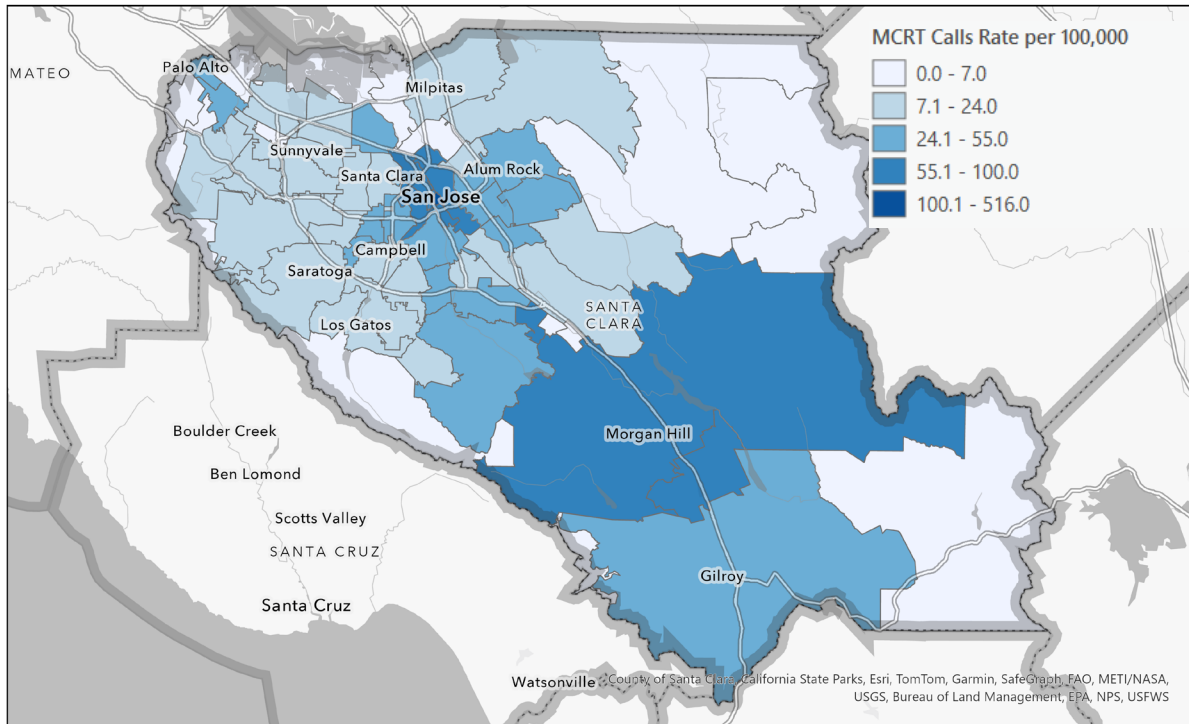
Calls Requiring a Field Visit



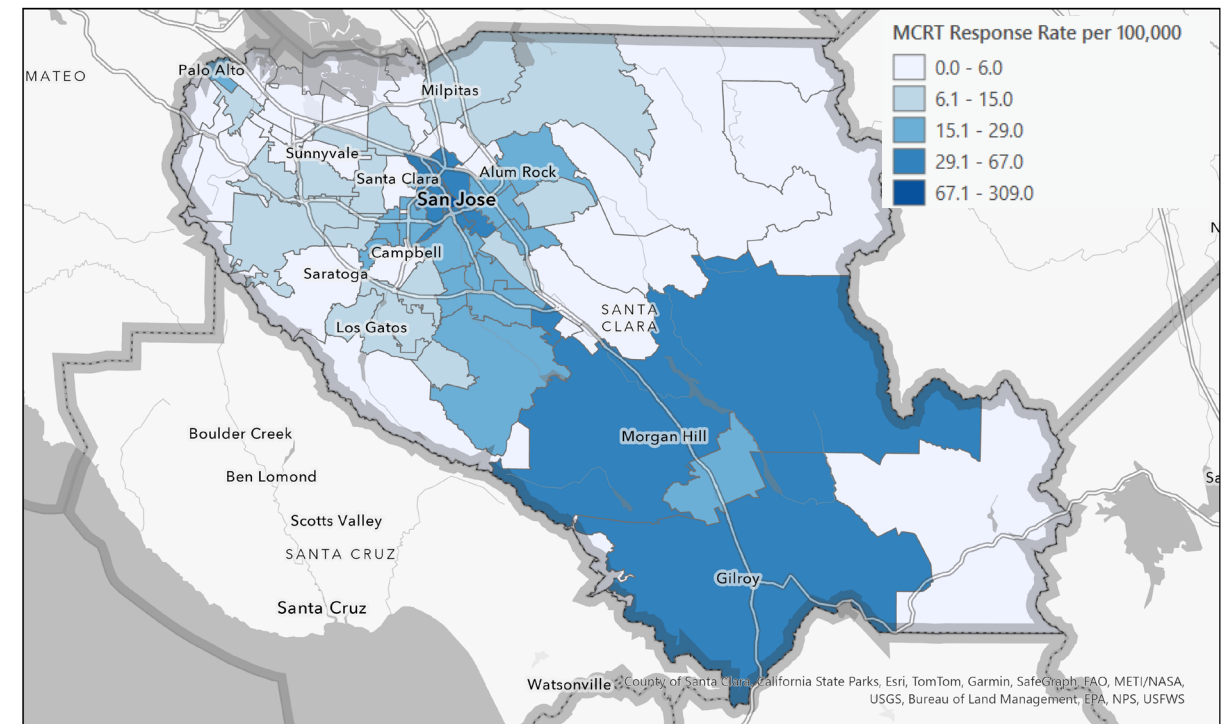
Zip code 95020 (Gilroy) and 95122 (San José) had the most MRSS calls with 33 calls each (resulting in 17 and 6 field visits, respectively). Zip code 95136 (San José) had the most MRSS field visits, with 18 field visits, followed by 95020 (Gilroy) with 17 field visits.

MCRT Heat Maps

All Calls Referred to MCRT



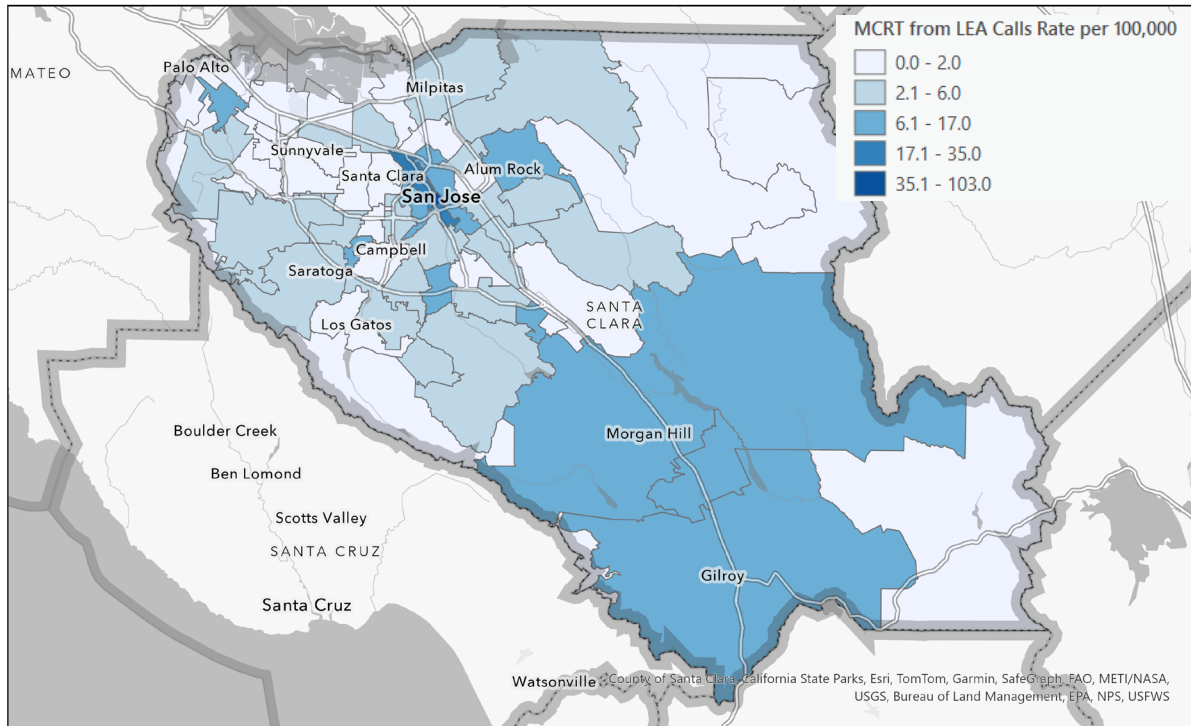
All Calls Requiring a Field Visit



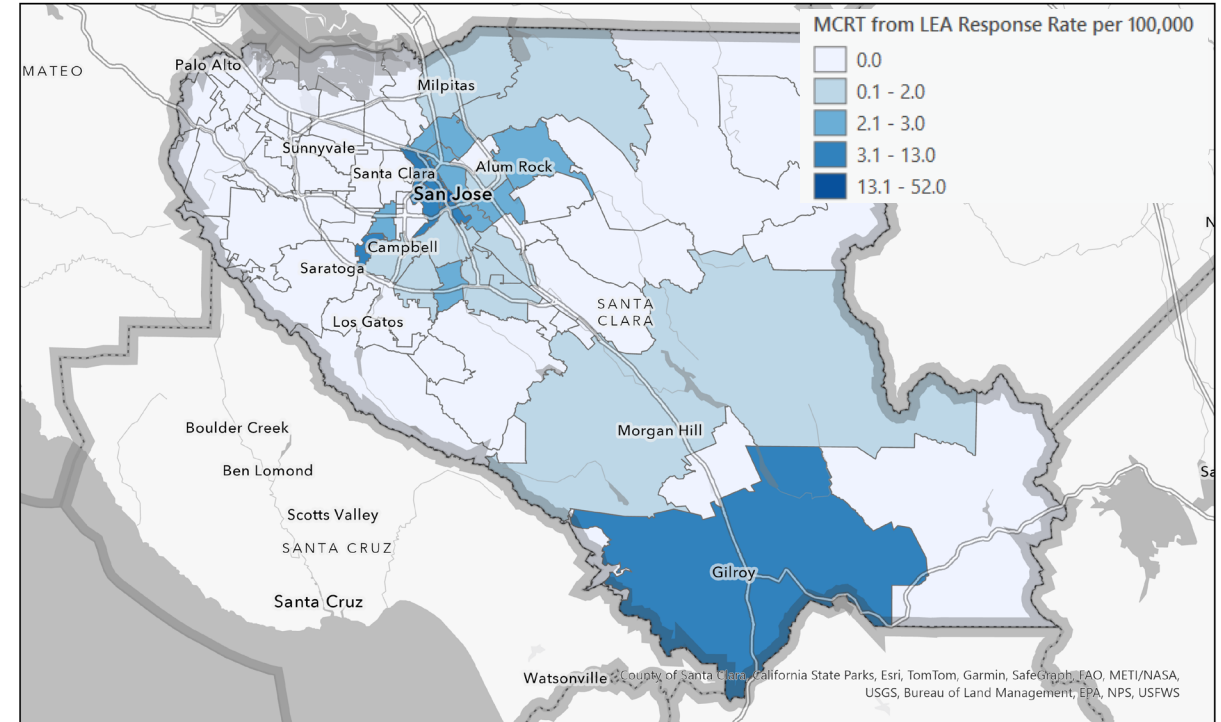
Zip code 95112 (San José) had the most MCRT calls, with 45 calls (resulting in 25 field visits), followed by 95020 (Gilroy) with 35 calls (resulting in 23 field visits). Zip code 95037 (Morgan Hill) had the most MCRT field visits, with 26 field visits, followed by 95112 (San José) with 25 field visits.

MCRT Heat Maps

Only Calls Directly from LEAs to MCRT



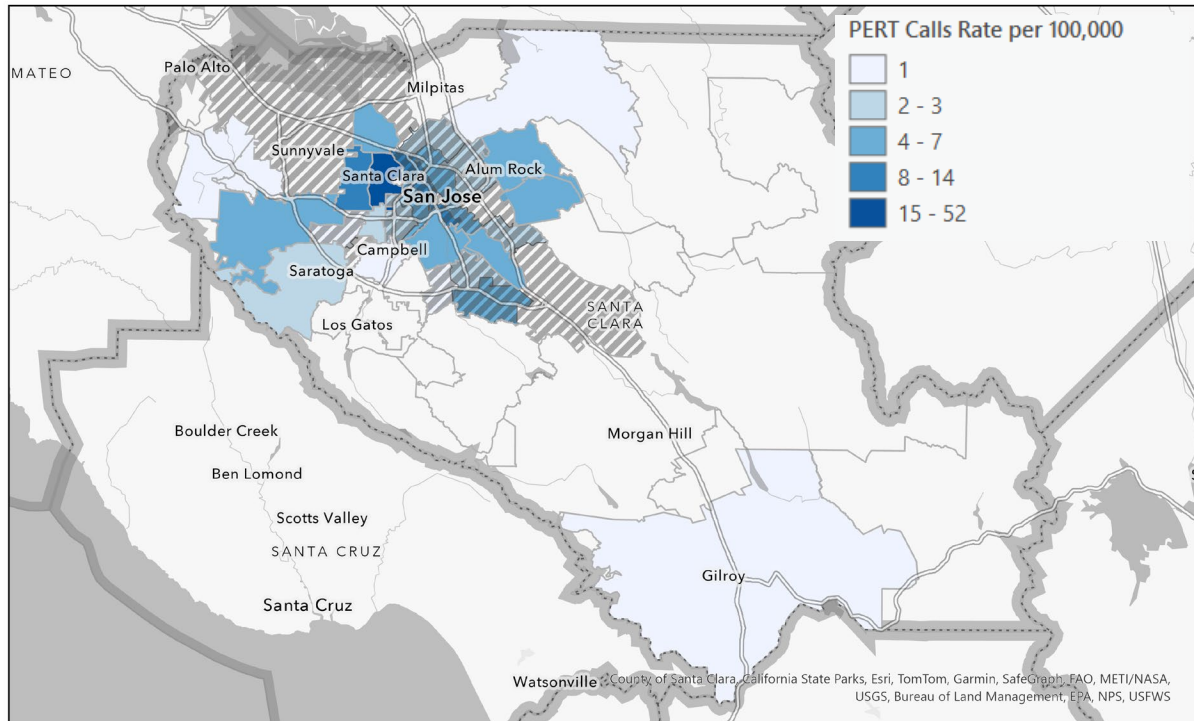
Only Calls Directly from LEAs Requiring a Field Visit



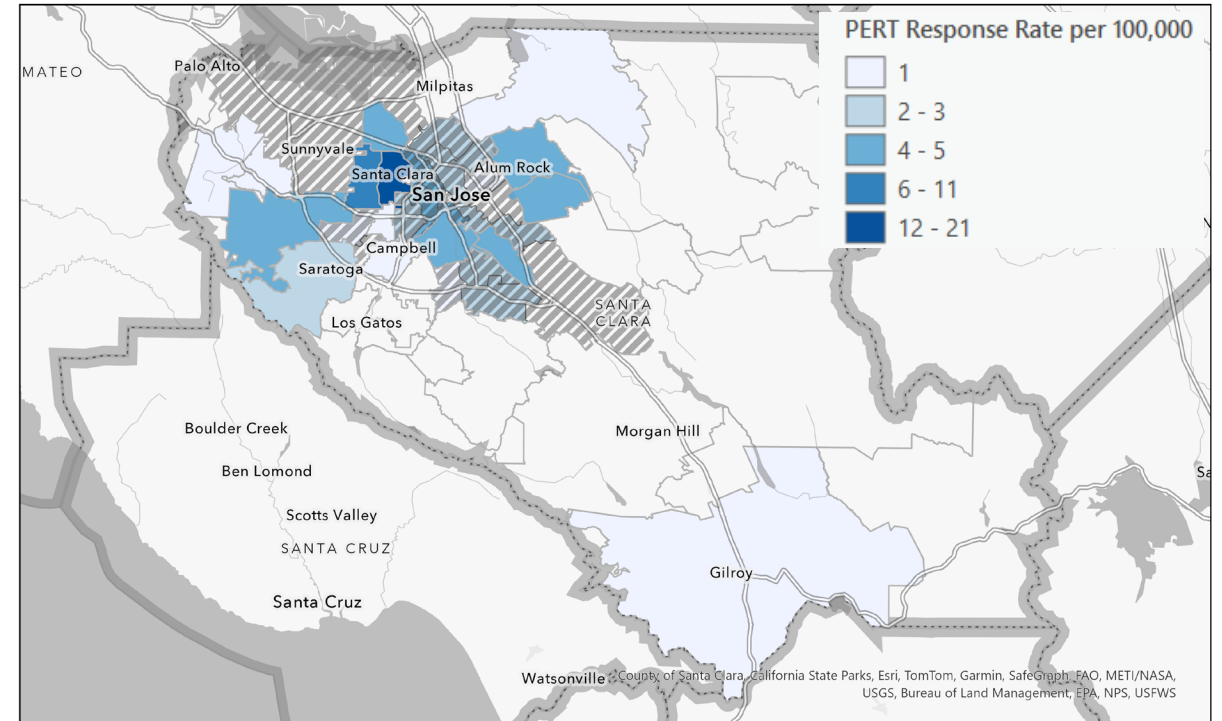
Zip code 95020 (Gilroy) had the most MCRT calls directly from LEAs, with 10 calls (resulting in 7 field visits), followed by 95127 (San José) with 9 calls (resulting in 2 field visits). Zip code 95020 (Gilroy) had the most MCRT field visits directly from LEAs, with 7 field visits, followed by 95126 (San José) with 3 field visits.

PERT Heat Maps

Calls Referred to PERT



Calls Requiring a Field Visit



Zip code 95050 (Santa Clara) had the most PERT calls, with 52 calls (resulting in 21 field visits), followed by 95110 (San José) with 14 calls (resulting in 5 field visits). Zip code 95050 (Santa Clara) had the most PERT field visits, with 21 field visits, followed by 95051 (Santa Clara) with 11 field visits.

PERT operates in the City of Santa Clara, City of San José, and through the Office of the Sheriff (serving Cupertino, Los Altos Hills, Saratoga, and the unincorporated areas of Santa Clara County).