**California Behavioral Health Planning Council**

# Systems and Medicaid Committee Agenda

Thursday, June 19, 2025
8:30 am to 12:00 pm

DoubleTree Marina del Rey
13480 Maxella Avenue
Marina del Rey, CA 90292
Panache I Room

Zoom Link
**Meeting ID:** 850 0854 0620
**Passcode:** SMC2025

**Join by phone:** +1 669 900 6833
**Passcode:** 6411469

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| **Meeting Focus:** | **Overview of Full-Service Partnership (FSP) Model in the Behavioral Health Services Act (BHSA)** | |
| **8:30 am** | **Welcome, Introductions, and Housekeeping**<br>*Uma Zykofsky, Chairperson and All Members* | |
| **8:35 am** | **Review and Accept April 2025 Draft Meeting Minutes**<br>*Karen Baylor, Chair-Elect and All Members* | **Tab 1** |
| **8:40 am** | **Overview of the Full-Service Partnership Model in the Behavioral Health Services Act and County Perspective of Implementation Impacts**<br>*Elissa Feld, Director of Policy, County Behavioral Health Directors Association (CBHDA)* | **Tab 2** |
| **9:15 am** | **Public Comment** | |
| **9:20 am** | **Overview of the Mental Health Services Act (MHSA) Full-Service Partnership 2024 Legislative Report**<br>*Kallie Clark, Social Policy Researcher, Behavioral Health Services Oversight and Accountability Commission (BHSOAC)* | **Tab 3** |
| **9:55 am** | **Public Comment** | |
| **10:00 am** | **Break** | |

**If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 10 working days prior to the meeting date.**

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|---|---|---|
| **10:15 am** | **County Perspective for Implementation of the Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) Within Full-Service Partnership Model**<br>*Debbie Innes-Gomberg, Deputy Director of Quality, Outcomes, and Training Division, Los Angeles County Department of Mental Health* | **Tab 4** |
| **11:00 am** | **Public Comment** | |
| **11:05 am** | **On-the-Ground Experience and Perspective of Provider Implementation of Assertive Community Treatment/Forensic Assertive Community Treatment Within Full-Service Partnership Model**<br>*Dawan Utecht, Senior Vice President, Chief Development Officer, Telecare Corporation*<br>*Danielle Vosburgh, Senior Director of Community Care Delivery, Telecare Corporation* | **Tab 5** |
| **11:50 am** | **Public Comment** | |
| **11:55 am** | **Wrap Up/Next Steps**<br>*Uma Zykofsky, Chairperson and All Members* | |
| **12:00 pm** | **Adjourn** | |

*The scheduled times on the agenda are estimates and subject to change.*

**Public Comment:** Limited to a **2-minute maximum** to ensure all are heard.

**Systems and Medicaid Committee Members**

Uma Zykofsky, Chairperson
Karen Baylor, Chair-Elect
Amanda Andrews
Jessica Grove
Ian Kemmer
Catherine Moore
Javier Moreno
Dale Mueller
Noel O'Neill
Liz Oseguera
Deborah Pitts
Karrie Sequeira
Marina Rangel
Tony Vartan
Susan Wilson

**Committee Staff**: Ashneek Nanua, Health Program Specialist II

**If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 10 working days prior to the meeting date.**

**TAB 1**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee

## Thursday, June 19, 2025

**Agenda Item:** Review and Accept April 2025 Draft Meeting Minutes

**Enclosures:** Systems and Medicaid Committee April 2025 Draft Meeting Minutes

**Background/Description:**

The Systems and Medicaid Committee will review the draft meeting minutes for the April 2025 Quarterly Meeting and have a chance to make corrections. The committee will then accept the meeting minutes.

# Systems and Medicaid Committee (SMC)

Meeting Minutes - Draft
Quarterly Meeting – April 17, 2025

**Members Present:**

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|---|---|---|
| Uma Zykofksy, Chairperson | Karen Baylor, Chair-Elect | Milan Zavala |
| Catherine Moore | Noel O'Neill | Tony Vartan |
| Javier Moreno | Susan Wilson | Jessica Grove |
| Elizabeth Oseguera | Dale Mueller | Deborah Pitts |

Anna Nguyen (stand in for Amanda Andrews)

**Staff Present:** Ashneek Nanua, Maydy Lo

**Presenters:** Dawn Kaiser, Julia Soto, Ryan Quist, Diana White, Lauren Cook

**Meeting Commenced at 8:30 a.m.**

## Item #1 Review and Accept January 2025 Draft Meeting Minutes

The Systems and Medicaid Committee reviewed the January 2025 draft meeting minutes. The committee accepted the meeting minutes with edits requested.

**Action/Resolution**
The approved minutes will be posted to the Council's Website.

**Responsible for Action-Due Date**
Ashneek Nanua – April 2025

## Item #2 Overview of the California Semi-Statewide Electronic Health Records System

Dawn Kaiser, the Senior Director of Analytics and Insights of the California Mental Health Services Authority (CalMHSA), provided an overview of the California Semi-Statewide Electronic Health Records System. The system is a customized solution to meet the complex business needs of California's public behavioral health system to support the county behavioral health plans which function as both a specialty treatment provider and a Managed Care Plan. The Semi-Statewide Electronic Health Record project first piloted in 3 counties in February and March 2023. Phase 1 included 20 counties participating in July 2023 to coincide with CalAIM payment reform. Phase 2 added 2 additional counties in September and October 2024, and Phase 3 will launch in 2025. All county partners were listed in the presentation.

System issues that prompted the need of the Semi-Statewide Electronic Health Record included an increase in service demand, short workforce supply, and the transformation of the behavioral health landscape. The goals of the Electronic Health Record include privacy and security, claiming, and state reporting. The Semi-Statewide Electronic Health Record also has innovative goals to improve clinical workflow, optimize outcomes, and provide interoperability.

Dawn Kaiser reported that the project had a mission-oriented team to provide the best service and experience to counties. The California Mental Health Services Authority (CalMHSA), the County Behavioral Health Director's Association (CBHDA), and the Department of Health Care Services partnered together to support implementation. There were challenges and complexities in the project such as technical issues, complications in standardizing workflows between facilities, and navigating new CalAIM programs and tools. Advocacy and technical assistance were provided via a Revenue Cycle Management team, Quality Assurance and Compliance team, Analytics and Insights team, and dashboarding. The California Mental Health Services Authority has a collective dashboard that provides critical cross-county financial insights for multi-county billable services and insights into service delivery and system performance. The dashboard includes visuals of potential outcomes for new policy implementation and shows whether the projected outcomes mirror expectations and allow for adjustments. The dashboard also offers population-specific data for race/ethnicity, language, and gender/sexual orientation.

CalMHSA Connex is a health care data aggregator and facilitator to facilitate all levels of interoperability for its users. The program supports several types of data systems for exchange. Connex also supports with closed loop referrals by integrating state-required screening and transition of care tools, electronically tracking referrals, and attaching clinical information to outbound referrals without a manual process via email. Dawn concluded the presentation and engaged the committee in a question-and-answer session.

<u>Committee Discussion:</u>

- Dawn Kaiser clarified that the annual charge for clients in the data dashboards are based on fiscal years.
- Committee members asked what kind of preparations counties must do for the claims process. Julia Soto from Placer County stated that there is direct entering of information or uploading information for claiming. The California Mental Health Services Authority also works with the counties for denied claims.
- The California Department of Social Services (DSS) has been looking at the closed loop referral process for the Specialty Mental Health Services population. A representative from the Department of Social Services asked how their department may have access to the closed loop referral data, particularly for the children and youth population. Dawn Kaiser stated that Connex is a subscription service and the entities providing the referrals are the subscribers. Any entity can receive the referrals. Dawn stated that this example would be a helpful use case and will connect with the social services representative regarding this issue.

- A committee member asked how the California Mental Health Services Authority captures feedback from contracted providers. The member expressed concerns about interoperability of the program because some contracted providers have to go through documentation twice with beneficiaries. For instance, the organization would have to enter information into the Electronic Health Record for the American Society of Addiction Medicine (ASAM) and then into SmartCare, the Semi-Statewide Electronic Health Record System.
    - Dawn Kaiser stated that the California Mental Health Services Authority was formed by the county behavioral health plans which are in the roles of the county and providers of directly operated services. Managed Care functions and responsibilities do not require double-entry of information. Counties also make decisions on how to run their Electronic Health Record Systems and how they interact with contractors. The California Mental Health Services Authority seeks information from county plans that interact with provider networks to receive feedback from contracted providers.
    - Committee members recommended that the California Mental Health Services Authority directly communicate with contracted providers regarding challenges and areas for improvement.
- Committee members asked how data in the SmartCare system can be shared between entities. Dawn Kaiser stated that contracts and consents associated with the legal framework plays a role in being able to do this. The closed loop referral process is a step in this direction.
- Dawn Kaiser stated that the county plans that run mental health and Substance Use Disorder programs are on the same health record. Clinical Data Access Groups segment the Substance Use Disorder data from the mental health data unless the client consents to having the provider view information for both.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

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## Item #3 Public Comment

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Steve McNally asked what the role of the California Data Exchange Project is regarding interoperability tools if the data is interoperable, but the systems are not. He stated that he works on a strategic planning project for child welfare and this system seems to not be in the equation. Steve asked what percentage of California's counties are involved in the Semi-Statewide Electronic Health Records System. He expressed that it is important to meet timelines for implementation as well as manage expectations.

Gregory Fearon from the Sonoma County Behavioral Health Board stated that he was the Chair of the California Coalition of Local Data Health Managers in the 1990s and this group dreamed that something like the Semi-Statewide Electronic Health Record

would be possible and expressed appreciation for the work of the California Mental Health Services Authority. Gregory stated that he has been involved in homeless housing and homeless services over the last 25 years and is collecting data for Health Management Information System (HMIS) and Homeless Data Integration System (HDIS). He asked to what degree the claiming in the Semi-Statewide Electronic Health Records System relates to the management and program use of HMIS and HDIS as these two systems should be able to share data.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

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## Item #4 County Perspectives of California Semi-Statewide Electronic Health Records System

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Dr. Ryan Quist, the Behavioral Health Director for Sacramento County's Department of Behavioral Health, provided the large county perspective of implementing the Semi-Statewide Electronic Health System. He spoke about the decision-making process for the county to participate in the Semi-Statewide Electronic Health Record System. Sacramento County experienced many changes through the process which include the following:

- Payment reform was a major change that caused the county to rethink how to pay and get paid for services. This required large-scale redesign of the existing Electronic Health Record System and current staff were working at capacity. The shift from cost-based reimbursement to Fee-For-Service reimbursement introduced incentives because Fee-For-Service reimbursement can save administrative costs that can be directed to providing direct services.
- Counties must advocate for funding to the state. The County Behavioral Health Directors Association (CBHDA) typically surveys counties which requires each county to collect data from their individual Electronic Health Records for CBHDA to aggregate. With the Semi-Statewide Electronic Health Records, the California Mental Health Services Authority now has access to the data and can do some of the data aggregation and analysis for the counties. This has been an effective strategy to report what the counties are doing to the State of California.

Dr. Quist stated that the Semi-Statewide Electronic Health Record System requires ongoing improvement. The California Mental Health Services Act has worked closely with Sacramento County and other counties to develop and implement solutions. The Semi-Statewide Electronic Health Record System has allowed the opportunity to create solutions to technical barriers in the public behavioral health system with the California Mental Health Services Authority's assistance.

Julia Soto, the Quality Management (QM) Program Manager for Placer County Health and Human Services, shared the small to medium county perspective of implementing the Semi-Statewide Electronic Health System. Placer County was an early adopter of the Semi-Statewide Electronic Health Record System which allowed the county to avoid unnecessary updates to former electronic records systems once CalAIM was implemented and allowed for better navigation with payment reform.

Placer County experienced success with implementing the Semi-Statewide Electronic Health System including, but not limited to, administrative and technical capacities, quality improvement and assurance support, advocacy, and interoperability. Julia Soto described the following implementation successes for Placer County:

- Placer County met CalAIM's documentation standards.
- The County was able to use meta tagging for special populations, offer clinical desk guides, and create productivity reports in a consistent manner.
- The California Mental Health Services Authority (CalMHSA) sets up the program to include enrollment in uniform service codes, state reporting, and provider directory. Current and future statewide programs, service codes, and data requirements will be automatically created, tested, and deployed.
    - Successes for eligibility include the ability to automatically import the Medi-Cal Master Eligibility File into the health record, having real time eligibility data so all staff can check client eligibility, and actively managing client and program payors to maximize funding and tracking of funds spent per payor.
    - Quality improvement and quality assurance successes include the collection and formatting of state reports, implementing Mobile Crisis and Care Courts, and utilizing dashboards and reports provided by the California Mental Health Services Authority for monitoring and clinical use.
    - Billing successes include implementation of Medicare billing which estimates an $80,000 increase in revenue. Future billing and service codes will be maintained by the California Mental Health Services Authority. Additionally, rate changes updated automatically and there was a reduction in Medi-Cal denial rates.
    - Placer County found that the Electronic Health Record System meets federal interoperability standards and allows for solutions for the provider network via the CalMHSA Connex Program. The system allows for efficient chart auditing and monitoring.
    - The California Mental Health Services Authority assisted with advocacy by getting approval from the Department of Health Care Services (DHCS) for forms and state reporting. The California Mental Health Services Authority also assisted with External Quality Review Organization (EQRO) and audit support.

Placer County faced the following challenges with implementing the Semi-Statewide Electronic Health Record System:

- The system caused delays with establishing workflows, testing, and deploying new functionality.
- Local staff desired to validate reporting which reduced efficiencies of the system.
- The system does not give the ability to pull up multiple screens.

- It was challenging to lead staff changes during a time of rapid change.
- The medical team struggled with labs and other design elements of the program.

In summary, Placer County's experience as an early adopter of the Semi-statewide Electronic Health Record System has been challenging with maintaining system changes while implementing many state initiatives. Placer County improved on many measures for accountability dashboards after the new system was implemented. The county is achieving higher revenues due to decreased denials, increased billable services, and gained efficiencies. The system has allowed county staff to focus more on quality and less strictly on compliance. The county representatives concluded their presentations and answered questions from committee members.

Committee Discussion:

- The committee asked to what degree clients have access to their medical record in the behavioral health system as compared to the physical health system. The presenters indicated that SmartCare has a patient portal for counties to use. Sacramento County has challenges with some access to information since some of it is charted on paper. Managed Care Plans that manage the physical health system also have a lag in data access. Sacramento County is working on follow-ups after hospitalization but there is currently a lag in real-time data. Crisis navigators go into the emergency rooms to do this work. Counties are working with Managed Care Plans to determine how to share data.
- Committee members and presenters discussed the nuances of data interoperability. Interoperability is an ongoing process that depends on the behavioral health system infrastructure.
- Committee members expressed concerns about stigma for people with mental health and substance use disorder conditions. This stigma has an impact on the willingness for clients to share information and data.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #5 Public Comment

Steve McNally shared that someone stated that Colorado has a statewide Electronic Health Record. He asked the committee to verify if this is true.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #6 Adult and Children's System of are Provider Perspectives of the California Semi-Statewide Electronic Health Records System

Lauren Cook, Executive of the Deputy Chief Operations Office at Turning Point Community Programs, presented the adult system of care provider perspective and experience utilizing the Semi-Statewide Electronic Health Record System. Turning Point operates in multiple counties. Lauren described the following challenges with implementing the new health record system:

- There are challenges with multi-county data entry. Each county has unique access requirements, training needs, and login steps. Counties also support different features of the Electronic Health Record System which causes confusion for staff. Additionally, not all counties have the same documentation guidelines and available procedure codes, which creates difficulties for standardizing utilization of the system.
- The new system also has impacts on workflow efficiencies. For instance, Full-Service Partnership requirements need data to be entered in multiple systems. Slow loading times compound workflow interruptions, and forms must be closed and reopened to enter information for different members which causes form navigation issues.
- There are program reporting difficulties due to different access levels and available reports across counties, missing reports since previously available reports are no longer accessible, and limited details about enrolled clients and billable services.
- Counties have differences with how they train their staff which creates confusion. More training is needed for administrative and leadership on the system's functions. Regarding state reporting, data collection remains difficult with duplicative entry requirements.
- Psychiatrists at the organization reported issues with opening and closing separate documents on forms and poorly organized documents lack clear and consistent labeling across programs. Additionally, there is slow and glitchy system performance and note templates did not fit procedure codes.
- Mental Health Urban Care Clinics reported benefits such as access to others' notes and substance use treatment documents as well as linkage to residential treatment waitlists. Challenges included billing issues with minimum time requirements, missing diagnoses in reports, and random error codes.
- Efficiency issues include the inability to open multiple documents simultaneously, slow chart loading, and frequent disruptive updates.

There are opportunities for improvement via standardized monitoring to create details reports across counties, enhanced integration and linkage to emergency departments and pharmacy records, advanced master document capabilities and key word searches, and data extraction to develop reliable reports that inform clinical work. Standardization addresses the county differences in training and efficiency. Additionally, better connections with other systems enhance value.

Laura Heintz, Chief Executive Officer, Stanford Sierra Youth & Families, presented the children's system of care provider perspective and experiencing utilizing the Semi-Statewide Electronic Health Record System. Stanford Sierra provides community-based mental health treatment, juvenile justice intervention, substance use prevention and treatment, and child welfare services. Like Turning Point Community Programs, Stanford Sierra experiences administrative burden. Stanford Sierra received Providing Access and Transforming Health (PATH) funding for CalAIM readiness and learned lessons such as the need to have capacity for interoperability for future efficiencies. All counties require training on the Semi-Statewide Electronic Health Record training during onboarding.

Efficiencies and benefits for utilization of the Semi-Statewide Electronic Health Record System include the following:

- Automatic access to referral notes about attempts to contact family and ability to add information into the same record to streamline the referral process.
- Immediate viewing of notes entered by other providers when a family has signed a release that shares information between providers.
- Ability to update the care plan and problem list within the note itself.
- Ability to send details that apply to each participant in a group to their individual note and adjust the note for that specific participant.
- The discharge paperwork is efficient. Families sign consents directly in the system.

There were also reported challenges with utilizing the Semi-Statewide Electronic Health Record System. There is less documentation oversight from providers since staff directly submit the information in county systems. The last assessment is also not available after updating an assessment. There is also limited centralized communication when there is a change or error in the system. It can be difficult to get help from the California Mental Health Services Authority helpdesk. Since the system does not have productivity reports, Stanford Sierra runs their own reports with their own Electronic Health Record.

Laura Heintz shared opportunities with the new system. One opportunity for improvement would be consistent documentation across counties. Another opportunity would be real-time updates when state instructions change or are clarified. Additionally, interoperability of Electronic Health Records between counties, providers, and systems has the potential to help with information sharing and reduce administrative burdens.

<u>Committee Discussion:</u>

- Committee members and presenters expressed the need to create consistent communication for counties utilizing SmartCare and the need to educate counties on cohesive component and positive impacts. It would be helpful for counties to align Electronic Health Records and data collection as much as possible to help reduce burdens for providers.
- Committee members expressed that providers are not paid adequately for administrative costs and the costs of operating business and rule compliance.

- Committee members stated that interoperability and data sharing must be present for the Electronic Health Record to work. It is challenging for small providers to keep up with the system changes and costs associated with the changes.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #7 Public Comment

Chad Costello, Executive Director for the California Association of Social Rehabilitation Agencies (CASRA), stated that Turning Point is one of CASRA's associations. He stated that certified peer providers are becoming locked out of other services they were previously able to bill. He expressed that peers are being directed to not bill under the peer codes for crisis services which are not built into the peer codes. Dawn Kaiser from the California Mental Health Services Authority shared that the peer codes encapsulate all the other services and procedure codes that peers used to be able to provide. For instance, a rehabilitation service can be claimed under the peer code. Peers are being asked to use this code set is to show the benefit of having certified peers. Dawn added that crisis codes are also subsumed under the three peer codes and payment reform allows payment for the provider type rather than the procedure code.

**Action/Resolution**
N/A
**Responsible for Action-Due Date**
N/A

## Item #8 Wrap Up/Next Steps

The Committee Officers will plan the agenda for the June 2025 Quarterly Meeting.

**Action/Resolution**
The Committee Officers will work with staff to plan the agenda for the subsequent quarterly meeting.

**Responsible for Action-Due Date**
Ashneek Nanua, Uma Zykofsky, Karen Baylor – June 2025

# California Behavioral Health Planning Council
# Systems and Medicaid Committee

## Thursday, June 19, 2025

**Agenda Item:** Overview of the Full-Service Partnership Model in the Behavioral Health Services Act and County Perspective of Implementation Impacts

**Enclosures**: Behavioral Health Services Act County Policy Manual: Full-Service Partnership Section (Pages 129-150)
Excerpt of Full-Service Partnership Section of Senate Bill 326: The Behavioral Health Services Act Bill Text (Pages 116-118)

**How This Agenda Item Relates to Council Mission**
*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The purpose of this agenda item is to provide the committee with an overview of Full-Service Partnership model in the Behavioral Health Services Act. The committee will use this information to help inform policy relating to the implementation of this program serving individuals living with mental health and substance use disorder conditions.

**Background/Description:**

On July 1, 2026, county behavioral health systems in California will be responsible for implementing a new Full-Service Partnership model under the Behavioral Health Services Act (BHSA). The Act requires counties to expand service delivery to individuals with substance use disorders.

Elissa Feld, Director of Policy, County Behavioral Health Directors Association (CBHDA), will present an overview of the Full-Service Partnership model in the Behavioral Health Services Act. The presentation will include an overview of Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) and the Intensive Case Management (ICM) tiers of Full-Service Partnerships. Additionally, the presentation will include information regarding the positive impacts and anticipated challenges associated with implementation from the county perspective. Capacity and transition of care issues, funding impacts, and workforce challenges will be discussed. The committee will have time to ask questions after the presentation.

*For a copy of the Full-Service Partnership in the Behavioral Health Services Act Presentation, please contact Ashneek.Nanua@cbhpc.dhcs.ca.gov.*

## Presenter Biography

Elissa Feld, Director of Policy, County Behavioral Health Directors Association (CBHDA)

Elissa joined the County Behavioral Health Director's Association (CBHDA) in 2020. As Director of Policy, she is responsible for leading policy analysis and administrative advocacy to advance CBHDA's strategic priorities for California's county behavioral health agencies. Areas of focus include the Medi-Cal Specialty Mental Health and Drug Medi-Cal programs, California's 1915(b) and 1115 Medicaid waivers, data exchange and interoperability, Medicaid quality initiatives, and the implementation of federal managed care and parity regulations. Prior to joining CBHDA, Elissa spent a decade working for community-based organizations, providing Medi-Cal specialty mental health services to both youth and adults, and earned a Master's degree in Public Policy from California Polytechnic State University in San Luis Obispo.

**TAB 3**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee

## Thursday, June 19, 2025

**Agenda Item:** Overview of the Mental Health Services Act (MHSA) Full-Service Partnership 2024 Legislative Report

**Enclosures**: Full-Service Partnerships 2024 Legislative Report

**How This Agenda Item Relates to Council Mission**
*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The purpose of this agenda item is to provide the committee with an overview of Full-Service Partnership outcomes in the Mental Health Services Act in 2024. The committee will use this information to help inform policy relating to the implementation of this program serving individuals living with mental health and substance use disorder conditions.

**Background/Description:**

Senate Bill 465 directs the Commission to provide biennial reports to the Legislature on the operations of Full-Service Partnerships and recommendations on improving outcomes for Full-Service Partnership clients. The Full-Service Partnership 2024 Legislative Report is the second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services. This current report has two priorities. The most essential of these is to present the required information to the Legislature as directed by Senate Bill 465. The second priority is to examine FSPs as systems of care and illuminate how system-level issues, such as programmatic inconsistencies and State-mandated data collection and reporting policies and practices, impact quality of care and client outcomes. This is followed by a set of findings and recommendations.

Kallie Clark, the Social Policy Researcher for the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), will present an overview of the Full-Service Partnership 2024 Legislative Report under the Mental Health Services Act (MHSA) structure. The committee will have time to ask questions after the presentation.

*For a copy of the presentation, please contact Ashneek.Nanua@cbhpc.dhcs.ca.gov.*

**TAB 4**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee

## Thursday, June 19, 2025

**Agenda Item:** County Perspective for Implementation of the Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) Within Full-Service Partnership Model

**Enclosures**: Los Angeles County Department of Mental Health Implementation of Full-Service Partnership (FSP) Program June 2025 Presentation

**How This Agenda Item Relates to Council Mission**
*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The purpose of this agenda item is to provide the committee with a county's perspective to consider how local entities plan to implement the Full-Service Partnership model under the Behavioral Health Services Act. The committee will use this information to help inform policy relating to the implementation of this program serving individuals living with mental health and substance use disorder conditions.

**Background/Description:**

On July 1, 2026, county behavioral health departments in California will be responsible for implementing a new Full-Service Partnership model under the Behavioral Health Services Act (BHSA). Debbie Innes-Gomberg, the Deputy Director of Quality, Outcomes, and Training Division at the Los Angeles County Department of Mental Health, will present on Los Angeles County's experience implementing Full-Service Partnerships under the Mental Health Services Act (MHSA) along with the anticipated changes of implementing the new Full-Service Partnership model under the Behavioral Health Services Act. The presentation will include information about the county's plans to implement Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) and the Intensive Case Management (ICM) within the Full-Service Partnerships. Additionally, the presentation will cover insights on how the county will address the substance use disorder services component under the new model. Additional items of discussion will include potential workforce and funding impacts as well as how the county plans to meet the fidelity requirements under the new model.

Committee members will have an opportunity to ask questions after the presentation.

## Presenter Biography:

Debbie Innes-Gomberg, Ph.D., Deputy Director of Quality, Outcomes, and Training Division at the Los Angeles County Department of Mental Health

Dr. Innes-Gomberg is a Deputy Director for the Los Angeles County Department of Mental Health with responsibility for Quality Improvement, Quality Assurance, Outcomes and Training.

Over the course of her 33-year career with Los Angeles County, she has assumed leadership roles, overseeing the administration of the Mental Health Services Act (MHSA) from 2009 to 2019, outcome evaluation from 2006 until the present, prevention services, adult services, Jail Mental Health Services and served as a District Chief for the Long Beach/South Bay areas of Los Angeles County for 6 years.

Dr. Innes-Gomberg is a member of the American and California Psychological Associations, as well as their Public Service Divisions (CPA- Div. 4 and APA- Div 18), including service as past-Chair of CPA's Division 4. She was the 2023 Chair of the California Quality Improvement Committee (CalQIC) Conference. She has served as the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board. She is a champion of using data to manage systems and programs.

**TAB 5**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee

## Thursday, June 19, 2025

**Agenda Item:** On-the-Ground Experience and Perspective of Provider Implementation of the Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) Within Full-Service Partnership Model

**Enclosures**: Telecare Corporation Implementation of Full-Service Partnership (FSP) Program June 2025 Presentation

**How This Agenda Item Relates to Council Mission**

*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The purpose of this agenda item is to provide the committee with a multi-county provider perspective to consider as local entities implement the Full-Service Partnership model under the Behavioral Health Services Act. The committee will use this information to help inform policy relating to the implementation of this program serving individuals living with mental health and substance use disorder conditions.

**Background/Description:**

Telecare Corporation opened California's first Full-Service Partnership in partnership with Alameda County in 1994 and now operates 49 Full-Service Partnerships in 15 California counties. Dawan Utecht, the Senior Vice President and Chief Development Officer, and Danielle Vosburgh, the Senior Director of Community Care Delivery at Telecare Corporation, will share their organization's experience with delivering Full-Service Partnership services in multiple counties including challenges, client outcomes, and success stories. The presenters will also discuss the alignment between the current Full-Service Partnership model and the new model under the Behavioral Health Services Act which will include Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT), and Intensive Case Management (ICM). Additional discussion items will include workforce impacts, staffing models, populations of focus, and impact to the adult system of behavioral health care. The presenters will also discuss how Telecare plans to address the substance use disorder component under the new Full-Service Partnership model.

Committee members will have an opportunity to ask questions after the presentation.

*For a copy of the presentation, please contact Ashneek.Nanua@cbhpc.dhcs.ca.gov.*

**Presenter Biographies:**

Dawan Utecht, Senior Vice President, Chief Development Officer, Telecare Corporation

Dawan Utecht is the Chief Development Officer for Telecare Corporation, overseeing Telecare's Development Department since January 2022. In this role, Dawan is responsible for all new business development, start-up operations, strategic growth, customer relations and government relations.

Prior to joining Telecare, Dawan served in leadership positions in both government and the private sector, including serving 8 ½ years as the Director of Behavioral Health and Public Guardian in Fresno County. Previous to that role, Dawan served in a variety of healthcare executive roles including as the Chief Executive Officer of an adult acute inpatient psychiatric hospital within a large hospital system in Fresno. Dawan has held leadership positions in the California Behavioral Health Directors Association and the California Mental Health Services Authority (CalMHSA) Joint Powers Authority, along with serving on the Fresno County First 5/Children and Families Commission, Community Corrections Partnership and the California Future Workforce Commission Behavioral Health Subcommittee. Dawan currently serves on the California Behavioral Health Task Force, the Department of Health Care Services' Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) and CalAIM Behavioral Health Committee, as well as the Community Assistance, Recovery, and Empowerment (CARE) Act Services and Supports Subcommittee.

She holds a Bachelor of Science from University of California Los Angeles and an Master of Science from Columbia University.

Danielle Vosburgh, Senior Director of Community Care Delivery, Telecare Corporation

Danielle Vosburg, LCSW serves as the Senior Director of Community Care Delivery at Telecare Corporation, where she provides strategic and operational support to programs across multiple states and over 20 California counties. Since joining Telecare over 15 years ago, she has held leadership roles with increasing responsibility and has overseen a wide range of programs including Full Service Partnership (FSP), Assertive Community Treatment (ACT), Assisted Outpatient Treatment (AOT), and Intensive Case Management (ICM) across several counties in California.

With a deep commitment to recovery-focused, evidence-based behavioral health care, Danielle has led diverse teams in delivering complex services to individuals with serious mental illness. She is known for her ability to drive operational excellence while fostering strong, values-based cultures within programs.

In her current role, she works across Telecare's community care portfolio with close to 100 programs serving 9,750 clients to ensure high-quality service delivery, improve program performance, and support local leadership in meeting both organizational and partner goals. She is passionate about breaking down systemic barriers to care, building collaborative teams, and ensuring services align with the needs and values of the communities served.

She holds a Bachelor of Arts in Psychology and history from UC Santa Cruz and an Master of Social Work with an emphasis in community-based mental health from California State University East Bay.

Telecare Corporation

## California Behavioral Health Planning Council's System and Medicaid Committee

# How Telecare Implements FSPs

Dawan Utecht, Chief Development Officer
Danielle Vosburg, Senior Director of Community Care Delivery

# Scope of Telecare's Full Service Partnerships

- 46 FSP programs across 16 counties
- Total of 6,810 FSP slots
- Breakdown of FSP services/specialty populations
  - **Assisted Outpatient Treatment (AOT):** 6 programs/357 slots
  - **Care Court:** 5 programs/233 slots
  - **Justice-Involved:** 11 programs/1,116 slots
  - **Older Adult:** 1 program/119 slots
  - **TAY:** 2 programs/75 slots
  - **Fidelity ACT:** 13 programs (3 counties)/1,796 slots

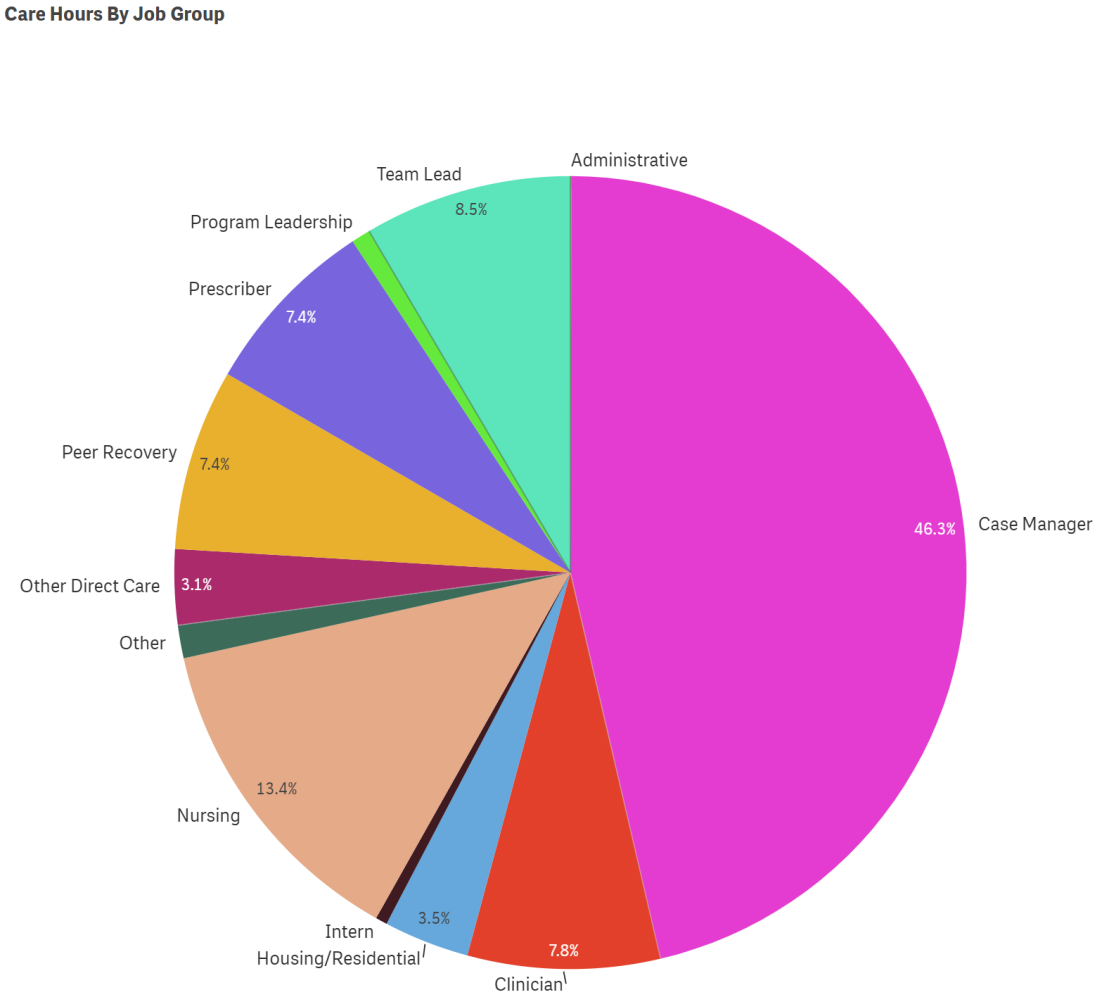
    *10 ACT, 3 FACT

# Telecare's non-FSP community services

- Short-term Intensive Case Management (60-90 days)
- Intensive Case Management (Adults, Older Adults)
- Probation/AB109 + CONREP FACT
- IHOT/Outreach programs
- Medication clinic (with light case management/therapy)
- Strength-based case management for Older Adults (institutional case management)
- Permanent Supportive Housing + IMD Step Down Residential

# Telecare's FSP services

- High intensity of client care 10:1-12:1 client to staff ratio
- Target average direct-care hours per month **8.7** (aligned with fidelity ACT models = 2 hours per week)
- 24/7 crisis response, both phone/in person response available from a staff member of the FSP team
- Individualized services to meet the needs to the person served
- Prescriber services (psychiatrist or NP) – with an average follow up interval of 3-4 weeks for high and moderate intensity clients (can be increased as needed)
- Nurse Services (RN and/or LVN, or combination)
- Specialty services include:
  - Clinician
  - Employment Specialist
  - Substance Use Specialist
  - Peer Support Specialist
  - **Housing Support Specialist
- Tiered-Model FSPs offer a recovery focus and flexibility for step-down within the program while still serving a high needs population



# Tiered Model FSPs

- 13 programs across 5 counties
- Tiered Model:
  - High Intensity (ACT level services)
  - Moderate Intensity
  - Low Intensity (Graduation team)
- Provides opportunity to tailor treatment to the individual needs of the person served within the program
- Recovery-focus, minimizing transitions or disruptions in care, client can go back to a higher intensity team as needed
- This approach has expanded service capacity within the program and system of care (larger caseload for the low intensity teams)

# Fidelity ACT Experience

Telecare still operates one of California's oldest fidelity ACT programs, STRIDES in Alameda County

*This program participated in early research demonstrating that people who participate in ACT programs have more successful outcomes*

## California ACT: 13 fidelity-ACT programs in 3 counties

- Experience using DACTS, SAMHSA, and TMACT models
- "High fidelity" is a contract requirement, measured by 3rd party, 80% = high fidelity
- We operate fidelity-ACT programs in Oregon, Washington, and Arizona as well
- New programs are typically given 1-2 years to reach full high fidelity
- Fidelity ACT services have been especially effective with clients transitioning out of long-term institutionalized settings

# Challenges with transition to fidelity ACT

- Focus on centralized scheduling practices has allowed us to increase efficiency for difficult to fill and expensive prescriber roles

  Allowed us to reduce overall prescriber hours while maintaining high level of direct-care and flexibility to still meet clients' needs

  Example:

  An FSP serving 250 clients would have 1.5 FTE prescriber

  A fidelity ACT FSP serving 250 clients would require 2.5 FTE prescriber

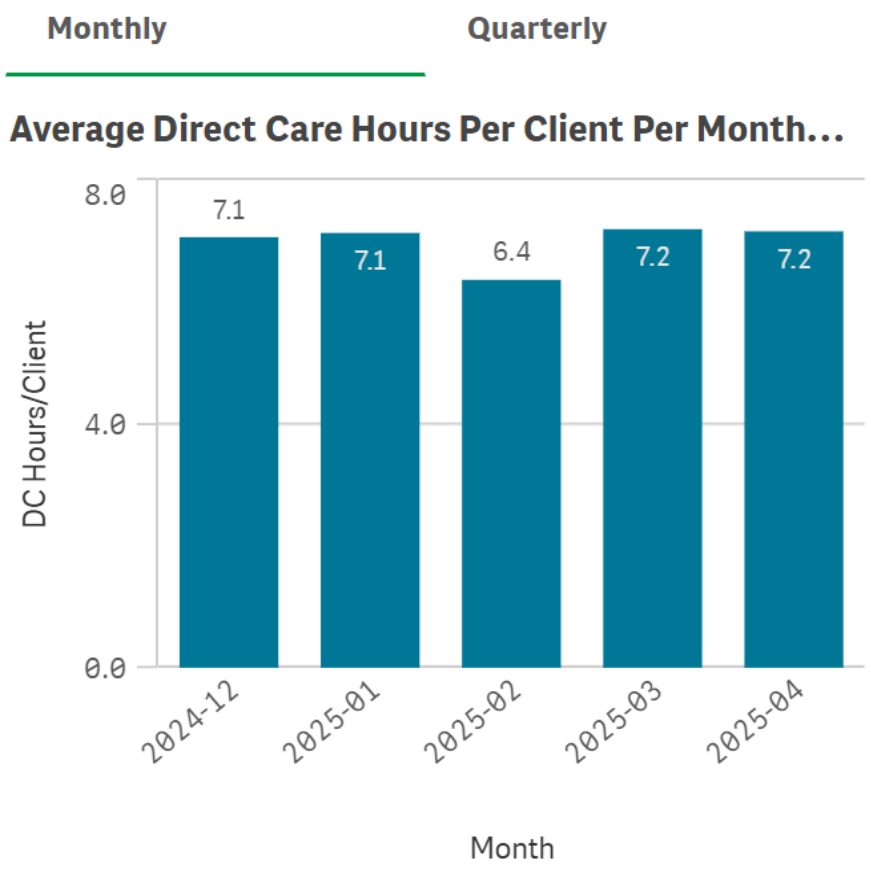
- Implementation of telehealth services as a response to challenges in rural communities
  - Telehealth prescribers are a necessity in some counties that serve a predominantly rural community where there are limited prescribers
  - Utilization of telehealth clinicians and nurses as needed to provide programs with continuity of care when there are staffing challenges (not as a permanent solution in most cases)

# Staffing Model FSP and ACT

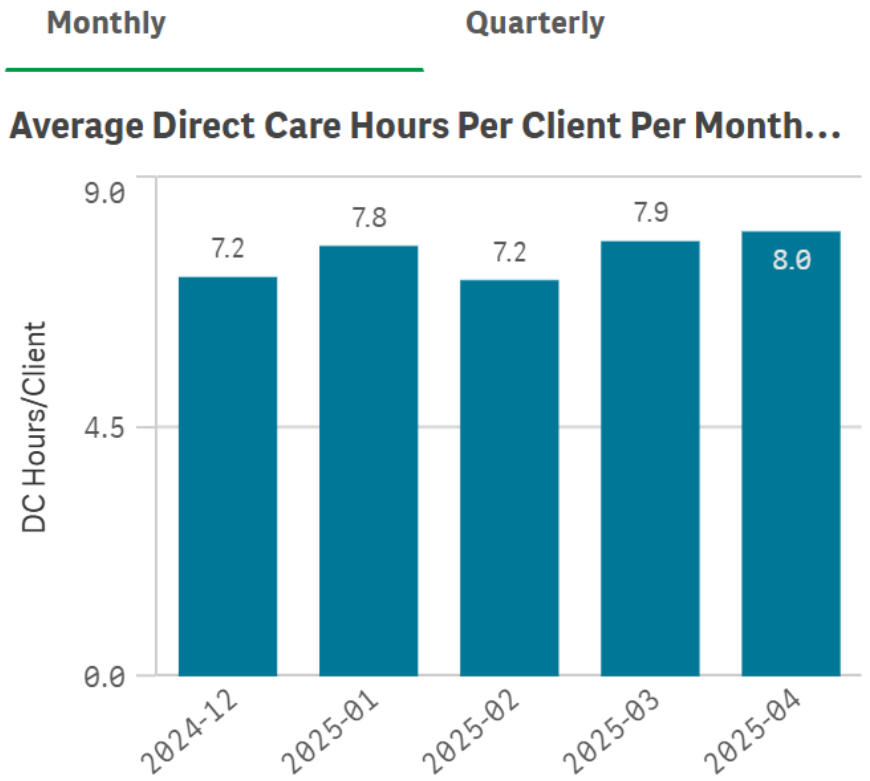
- ACT Models require strict staffing pattern adherence to meet high fidelity
  - This protects resources for minimum levels of staffing/care within programs in the system of care
  - However, provides limited flexibility to staff to the regional needs or to create staffing efficiencies while maintaining client care
  - The different ACT models have different specialty staffing requirements:
    - Psychiatrist vs NP vs combination
    - RN vs LVN vs combination
    - Employment Specialist (different FTE requirements across models), Substance Use Specialist (different FTE requirements across models), Peer Support Specialist (TMACT/SAMHSA), Housing Specialist (not required in any model)
  - These staffing requirements can impact the cost to run the program as well as ability to fill positions
  - Existing non-ACT FSPs will likely need to adjust staffing/align specific roles to meet fidelity models (impact will vary depending on the ACT model)

# Intensity of Service ACT vs non-ACT FSP

## Fidelity ACT programs in California




## Non-ACT FSP programs in California



# Importance of Substance Use Disorder treatment

- In FY2024 Telecare was awarded a grant to participate in a Learning Collaborative with Health Management Associates and DHCS – our FSPs in LA County participated
- During this Learning Collaborative Telecare made *significant advances in our ability to identify and serve clients with co-occurring substance use disorders*
- Staff were trained in Cognitive Behavioral Interventions – Substance Use Adults (CBI-SUA) by University of Cincinnati
- We made modifications to our EHR (Avatar) to promote universal screening for substance use, including decision support and intervention prompts to encourage appropriate follow-up
- Training sessions were offered for Medication Assisted Treatment (MAT)
- Implementation of SAMHSA's Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Toolkit with the targeted goal of becoming Dual Diagnosis Capable (DDC)
- Rolled out now across the organization (including all FSP/ACT programs) by June 2025

# Impacts to Adult System of Care

- Importance of providing high intensity, high quality services to the most vulnerable, high needs individuals
- Access to care consideration: delays with access to services primarily occur with clients navigating complicated systems of care, identifying who meets eligibility criteria for persons served, and potentially with locating client if insufficient information is provided at referral
  - Increase need to manage flow between programs may pose challenge for counties
- Need to consider what housing resources are provided, how they are managed within the system of care, and do they meet the needs of the target population of the program
  - Example: Housing needs differ in a step-down population versus a chronically unhoused/underserved population
  - FSPs require a spectrum of housing options available to clients (Licensed B&C - Permanent Supportive Housing)
- Systems of care must offer a spectrum of services with easy transition within/between services. We believe this can include:
  - Fidelity ACT FSPs
  - Non-ACT FSPs/Tiered FSPs
  - Intensive Case Management
  - Other intensive services that meet specific regional needs