Systems and Medicaid Committee Agenda

Thursday, April 17, 2025
8:30 am to 12:00 pm

Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630
Placer Room

Zoom Link
Meeting ID: 820 3697 7864
Passcode: SMC2025

Join by phone: 1-669-900-6833
Passcode: *1572830#

8:30 am	**Welcome, Introductions, and Housekeeping** *Uma Zykofsky, Chairperson and All Members*	
8:35 am	**Review and Accept January 2025 Draft Meeting Minutes** *Karen Baylor, Chair-Elect and All Members*	**Tab 1**
8:40 am	**Overview of the California Semi-Statewide Electronic Health Records System** *Dawn Kaiser, Senior Director of Analytics & Insights, California Mental Health Services Authority (CalMHSA)*	**Tab 2**
9:35 am	**Public Comment**	
9:40 am	**County Perspectives of the California Semi-Statewide Electronic Health Records System** *Ryan Quist, Behavioral Health Director, Sacramento County Department of Behavioral Health Services* *Julia Soto, Quality Management (QM) Program Manager, Placer County Health and Human Services*	**Tab 3**
10:35 am	**Public Comment**	
10:40 am	**Break**	
10:55 am	**Adult and Children's System of Care Provider Perspectives of the California Semi-Statewide Electronic Health Records System** *Diana White, President and Chief Executive Officer, Turning Point Community Programs* *Laura Heintz, Chief Executive Officer, Stanford Sierra Youth & Families*	**Tab 4**

11:50 am **Public Comment**

11:55 am **Wrap Up/Next Steps**
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	Javier Moreno	Karrie Sequeira
Jessica Grove	Dale Mueller	Walter Shwe
Ian Kemmer	Noel O'Neill	Marina Rangel
Steve Leoni	Liz Oseguera	Tony Vartan
Catherine Moore	Deborah Pitts	Susan Wilson

Committee Staff: Ashneek Nanua, Health Program Specialist II

TAB 1

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, April 17, 2025

Agenda Item: Review and Accept January 2025 Draft Meeting Minutes

Enclosures: January 2025 Draft Meeting Minutes

Background/Description:

The Systems and Medicaid Committee will review the draft meeting minutes for the January 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 – January 16, 2025

Members Present:

Uma Zykofksy, Chairperson	Karen Baylor, Chair-Elect	Milan Zavala
Catherine Moore	Noel O'Neill	Marina Rangel
Javier Moreno	Ian Kemmer	Susan Wilson
Elizabeth Oseguera	Dale Mueller	Deborah Pitts

Staff Present: Ashneek Nanua, Naomi Ramirez

Presenters: Marlies Perez, Elissa Feld, Robb Layne, Ian Kemmer, Michelle Smith, Chil Lam, Glenda Aguilar

Meeting Commenced at 8:30 a.m.

Item #1 Review and Accept October 2024 Draft Meeting Minutes

The Systems and Medicaid Committee reviewed the October 2024 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 – January 2025

Item #2 Overview of Substance Use Disorder Services in Behavioral Health Services Act (BHSA) Full-Service Partnerships

Marlies Perez, the Behavioral Health Transformation Project Executive and Chief of the Community Services Division at the Department of Health Care Services, provided an overview of substance use disorder services in the Behavioral Health Services Act Full-Services Partnerships. The definition of substance use disorders is a diagnosed substance-related disorder that meets the diagnostic criteria of "severe" as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Marlies provided an overview of the Behavioral Health Transformation timeline and stated that counties must conduct Assertive Field-Based Initiation and Full-Service Partnership teams must be capable of supporting individuals with co-occurring mental health and substance use conditions. The Behavioral Health Services Act has a 35% funding allocation for Full-Service Partnerships.

Marlies Perez reviewed the required and allowable services for Full-Service Partnerships. There is a model for the adult Full-Service Partnership standards of care with Assertive Community Treatment as the highest level of care and Intensive Case Management as a step-down level of service. Marlies explained the components of each level of care and best practices for outreach and field-based programs. Counties can collaborate and pool together financial resources to expand and support field-based mobile services and open-access clinics. Counties may also refer residents across county programs. Counties must describe the program design and meet the requirements for Assertive Field-Based Treatment requirements by July 1, 2029.

The committee engaged Marlies Perez in a question-and-answer session upon conclusion of the presentation. The following key points were discussed:

- Committee members expressed concerns about the timeline for the 3-year integrated plan requirements. Marlies stated that the Department of Health Care Services will provide a template and guidance for the plan. She added that small counties (populations less than 200,000) may ask for an exemption for the housing intervention component of the first 3-year plan, and all counties may ask for transfer of funds to another category under the Behavioral Health Services Act. The Department of Health Care Services also has deadlines for reviewing the integrated plans.
- There was a question about whether telehealth was an acceptable practice for rapid response Medication-Assisted Treatment in rural and small counties. Marlies stated that telehealth models can be utilized.
- A committee member shared that the original Full-Service Partnerships required teams and asked if Level 1 of the Full-Service Partnerships includes a team-based model. Marlies confirmed that Level 1 is a team-based model.
- There were comments from the committee that regulatory changes will be needed to improve rapid access to Medication-Assisted Treatment. Leveraging the Narcotic Treatment Programs (NTP) network will be critical. Leadership and policy changes are also needed due to the policy barriers that prevent the expansion of Narcotic Treatment Program services. It is important to make improvements to the existing system and remove barriers instead of creating a new system. Marlies stated that this is a priority for the Department of Health Care Services and will require shifts about views on the need to provide Medication-Assisted Treatment.

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

Item #3 Public Comment

Kaino Hopper, a volunteer for National Alliance on Mental Illness (NAMI) Sacramento, expressed appreciation for the Full-Service Partnerships Substance Use Disorder Program and provided a family member perspective. Kaino expressed hope that there will be understanding that families and support networks are healthy and that individuals may choose who their support people are. She reminded the committee that families are an invisible workforce and natural supports willing to help provide education and assistance.

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

Item #4 Policy and Provider Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships

Elissa Feld, the Director of Policy for the County Behavioral Health Directors Association (CBHDA), and Robb Layne, Executive Director for the California Association of Alcohol and Drug Program Executive, Inc. (CAADPE), presented to the committee on the challenges and opportunities for substance use disorder services in Behavioral Health Services Act Full-Service Partnerships. The presenters first explained the current landscape of Assertive Field-Based substance use disorder services which include mobile field-based programs, low barrier access to Medication-Assisted Treatment, and the support of co-occurring conditions in Full-Service Partnerships.

The California Association of Alcohol and Drug Program Executive, Inc. is using community treatment models with a whatever-it-takes approach in clinical settings. The organization is also integrating substance use disorder screenings as part of their workflows with linkages to residential care.

Tarzana Treatment Centers is known for their substance use disorder treatment and hold multiple Full-Service Partnership contracts that connect individuals to co-occurring care. The services are co-located and integrated. Tarzana's Full-Service Partnership model includes home visits, street outreach, mobile testing, and follow-up with transition-age youth experiencing or at-risk of experiencing homelessness. Robb Layne emphasized that Full-Service Partnerships should support individuals experiencing homelessness. Mobile approaches help individuals who may avoid traditional clinics due to stigma, transportation, or scheduling issues by meeting people where they are.

HealthRIGHT 360 has a successful model that integrates Alcohol and Other Drug (AOD) Counselors, Peer Support Specialists, and mental health clinicians in their Full-Service Partnership program to serve clients experiencing Serious Mental Illness (SMI) alongside their addiction. The organization also assists individuals with temporary and transitional supportive housing.

Robb Layne stated that providers that have embraced low-barrier models and minimum eligibility requirements have seen improvements in engagement and retention in treatment. By meeting the individual's immediate needs, providers have been able to address the gaps between seeking help and initiating medication. Additionally, including Alcohol and Other Drug (AOD) Specialists within Full-Service Partnership teams, ensuring consistent warm hand-offs between outpatient and residential care, and having aftercare planning are key best practices. Smoother transitions out of detox and better medication compliance for psychiatric and addiction medications are also important for success. Robb also emphasized a consumer-centered approach, flexible scheduling, and trauma-informed and culturally affirming practices as important.

The County Behavioral Health Directors Association surveyed the counties to identify what is already happening in Full-Service Partnerships. Elissa Feld stated that many outreach teams in the counties are currently funded by Mental Health Services Act funds. Counties have programs outside of behavioral health which include street medicine programs funded by other county departments or initiatives. The counties are working closely with Narcotic Treatment Program providers. Hospitals that work with county behavioral health departments engage in the California Bridge Program which includes partnerships with substance use disorder navigators. Medication-Assisted Treatment Clinics are built in accessible areas and not all counties have this. Many counties are engaging in Assertive Community Treatment. San Diego County and Santa Clara County are working with outside entities to assess their programs for fidelity.

Key discussion points for the county and provider challenges regarding substance use disorder services in Full-Service Partnerships include the following:

- **Workforce**
    - It is difficult to find prescribing providers to go into the field. Telehealth is an option for rural areas, but some clients have challenges building a therapeutic connection in a virtual format.
    - Smaller providers do not have robust or specialized training or the recruitment strategies that larger providers have, especially in rural communities. Smaller providers are often the culturally affirming programs. Smaller organizations also lose qualified staff to larger employers. This highlights equity and scaling issues for the behavioral health workforce.

- **Integration and training**
    - Substance use disorder residential treatment providers often do not have the training needed to support individuals with co-occurring disorders.
    - Riverside County is working with providers to provide services to clients with co-occurring conditions.

- There is a need to train both mental health and substance use providers on the fourth edition of the American Society of Addiction Medicine (ASAM).
- Integration and training are challenging for small and rural counties. Elissa Feld provided an example of success where a small county received a grant and worked with Aegis Treatment Centers to have mobile-field based services.
- It is important to know who is responsible for care outcomes. Providers, counties, and health plans need to work together to avoid duplication of services.
    - Los Angeles County has a program called the Care Health Action Management Platform (CHAMP) to view client records and track care plans in real time. The platform also requires a Memorandum of Understanding (MOU) to identify what provider handles physical health, mental health, substance use disorder treatment, and housing navigation. This prevents clients from going back and forth between multiple systems.
    - The Integrated Services for Mentally Ill Parolees (ISMIP) Program was designed to connect parolees with Serious Mental Illness to community-based mental health services upon release of carceral settings. The California Department of Corrections and Rehabilitation made contracts with local mental health and substance use disorder providers specifying responsibilities for medication management, housing, and case management. There were data sharing agreements, so providers have limited access to information like parole conditions and mental health history to develop integrated plans. The outcome was a single transition plan. This program has been cut.
    - The Enhanced Care Management Benefit under the California Advancing and Innovating Medi-Cal (CalAIM) Initiative supports integration but there are questions on what provider or entity is responsible for providing and billing for care coordination. Standardizing reporting and data sharing is an important piece under the leadership of the Department of Health Care Services via All Plan Letters (APLs) and Behavioral Health Information Notices (BHINs).
- The state is working on a data exchange through Part 2 regulation-compliant forms. There is a need for Part 2 of the substance use disorder data exchange centralized consent management platform to address barriers regarding 42 Code of Federal Regulations (CFR) Part II regulations. County behavioral health providers have been left out of data exchange funds and have advocated for this infrastructure to support counties, particularly small and medium-sized counties. Los Angeles County has been a leader in data exchange.

- **Stigma**
  - While stigma is difficult to measure, there is stigma in the substance use disorder community for both clients and providers.
  - Early dropouts occur in treatment programs due to stigma for medication.
  - Self-stigma also exists for clients. It is important to discuss trauma occurring with a substance use disorder diagnosis.
  - There is a need to integrate Harm Reduction Services in programs and Peer Support Specialists in care teams.
  - Committee members shared examples of substance use disorder providers who do not serve clients that have certain medications or mental health diagnoses.
  - There is stigma in reimbursement, paperwork, and parity. Substance use disorder providers receive the lowest reimbursement in the system and must fill out several forms for reimbursement.
  - There is a need to educate the public on Medication-Assisted Treatment.
  - The County Behavioral Health Directors Association worked on Assembly Bill 2995 which focused on removing stigmatizing language for mental health and substance use disorders.

- **Sustainability**
  - The Behavioral Health Services Act is a funding source created from the recalculation of Mental Health Services Act funding. Some counties face a net reduction of this funding, and the Act does not add clear value.
  - The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration is another funding source.
  - The Behavioral Health Services Oversight and Accountability Commission has funded workforce pilot programs.
  - The Department of Health Care Access and Information has distributed money for loan repayment programs.
  - Grant funding is critical. The California Health Care Foundation is funding a grant through the Department of Health Care Services to help small providers become certified in Substance Abuse Prevention and Control (SAPC). This is an example of how to support small providers to expand their networks.
  - San Diego County and Sacramento County have learning hubs or joint training sessions for mental health and substance use disorder providers. This is funded by the Mental Health Services Act or local workforce funds.
  - Los Angeles County is putting together a learning management system to help providers better understand substance use services, the updated American Society of Addiction Medicine criteria, and trainings to provide free continuing education credits.

- **Licensing and Certification**
    - The Department of Health Care Services has been engaging counties to ensure that multiple providers are present on multi-use campuses that have both substance use disorder and mental health services on the campus. One challenge for the campuses is the requirement for all outpatient substance use disorder programs be Alcohol and Other Drug (AOD) certified. There was a case where a county where counseling services were optional for with low barrier access to Medication-Assisted Treatment. The Department of Health Care Services updated the requirements to make counseling a required component for Medication-Assisted Treatment.

Key discussion points for the county and provider opportunities regarding substance use disorder services under the Behavioral Health Services Act Full-Service Partnerships include the following:

- **Further expansion of co-occurring teams**
    - Earn and Learn Programs help address the workforce issue and expand co-occurring teams.
    - There is a need to expand pay, training, and supervision. Supervision is often overlooked in budget planning. Flexible supervision may remove barriers for small organizations and counties to bring in workforce staff.
    - Alcohol and Other Drug Counselors have been added to the Mental Health State Plan Amendment to provide mental health services within their scope in the “Other Qualified Provider” billing code. However, it has been challenging to bill due to mental health and Drug Medi-Cal Certification. Alcohol and Other Drug Counselors can now bill for mental health services and receive the Alcohol and Other Drug Counselor rate rather than the lower rate for Other Qualified Providers. This will help sustainability.

- **Partnerships and collaboration**
    - Providers, colleges, and workforce agencies should collaborate to support the pipeline for behavioral health providers on integrated teams.
    - For-profit Medicaid providers can be part of the unified solution because they may have the culture of a non-profit.

- **California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Workforce Initiative**
    - The County Behavioral Health Directors Association advocated to prioritize Alcohol and Other Drug Counselors and prescribers working on the substance use delivery system. Alcohol and Other Drug Counselors are included in the loan repayment, scholarship, training programs, and recruitment and retention sections of the Workforce Initiative.
        - There is $120,000 student loan repayment funding for Alcohol and Other Drug Counselors.

        - Supervision is included for recruitment and retention to help with recertification, exam fees, and needed materials.
        - The Council should work with the Department of Health Care Access and Information to ensure small counties can access this funding.

- **Leveraging recent policy changes**
    - Providers assess whether they can afford to provide new services that the Department of Health Care Services offers.
    - Reimbursement rates need to be predictable.

- **Reducing stigma**
    - There is a need for a consumer-driven approach and ensuring a No Wrong Door Policy that fosters trust and consistent engagement to address stigma and access to services.

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

Item #5 Public Comment

Steve McNally from Orange County stated that he has a son with schizophrenia who receives county services. As a family member, Steve asked if stigma is the issue or if self-stigma is the issue. He expressed that it is important to model and talk about our own journeys. There is a need for a shared understanding between the state, counties, and family members and improved stakeholder processes to address communication issues. It is helpful to use and share an open data portal to see details at the county level and identify where the issues exist.

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

Item #6 County Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships

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Ian Kemmer, Behavioral Health Director for Orange County Health Care Agency, and Michelle Smith, Division Manager of Mental Health Services Act Programs, presented on enhancing co-occurring capabilities in the Orange County System of Care. Chil Lam, Program Manager for Intensive Outpatient Services and Glenda Aguilar,

Division Manager for substance use disorder services were present for the question-and-answer session with committee members.

Ian Kemmer discussed access to services via access lines, outreach and engagement, and No Wrong Door Policy. The following levels of care are included in the Drug Medi-Cal Organized Delivery System: outpatient treatment; intensive outpatient recovery services; residential treatment inclusive of individuals with co-occurring mental health challenges; low-intensity and high-intensity residential services; withdrawal management; and Medication-Assisted Treatment (MAT) Narcotic Treatment Programs (NTP). There are also supportive services such as housing services, supported employment, peer mentoring, and wellness centers. Specialty population services cater to Transition Age Youth, Pacific Asians, Older Adults, Latino, and Vietnamese populations.

The Full-Service Partnership model resides in Intensive Outpatient Treatment through contracted providers. Orange County also has the Assertive Community Treatment (ACT) model which is known as the county-operated Full-Service Partnership program. The first Full-Service Partnership program was for the older adult population. Ian shared the county's 10 Full-Service Partnership programs based on the populations of focus which include the populations mentioned above as well as the criminal justice population and collaborative courts.

The average adult population in Full-Service Partnerships had a co-occurring disorder. Co-Occurring services in the Full-Service Partnerships include multidisciplinary teams, comprehensive and integrated services, screening tools, and evidence-based practices. The process for individuals with co-occurring mental health and substance use disorders involve coordination and linking individuals from existing programs to the Drug Medi-Cal Organized Delivery System services.

The Enhanced Recovery Full-Service Partnership Co-Occurring Disorder Program is a voluntary program. The program includes voluntary drug testing and screening. In the program, participants attend 3 to 6 co-occurring groups per week, self help meetings twice per week, and check in weekly with the co-occurring treatment specialist. The program includes four stages based on amount of time in recovery. The program has 38 graduations to date.

Ian Kemmer shared current challenges and barriers to substance use disorder services. More training is needed to link individuals to substance use disorder services and have providers deliver co-occurring service. Stigma impacts client engagement and retention in services. There are also billing and documentation challenges such as ability for Alcohol and Other Drug Counselor to bill Medicaid for services to individuals with co-occurring disorders. Staff hiring and retention is a challenge as well as having limited providers.

Michelle Smith discussed changes to the continuum of care for the Behavioral Health Transformation based on Module 1 of the Behavioral Health Services Act. Full-Service

Partnerships would occur in outpatient and intensive outpatient services which is a step up in care from early intervention services and a step down from crisis and field-based services.

There was a higher percentage of funding for Full-Service Partnerships under the Mental Health Services Act Community Services and Supports funding category (51% of total funding) as compared to the Behavioral Health Services Act which requires 35% of total funds for Full-Service Partnerships. The Behavioral Health Services Act differs from the Mental Health Services Act because it defines the Full-Service Partnership levels of care into either high intensity services delivered to fidelity or Intensive Case Management. Additionally, the Behavioral Health Services Act requires counties to participate in Assertive Community Treatment (ACT) and Forensic Assertive Community Based Treatment (FACT), High Fidelity Wraparound, Individual Placement and Supports (IPS), and Assertive Field-Based Initiation for substance use disorders. The Mental Health Services Act did not require implementation of evidence-based practices to fidelity.

The Behavioral Health Services Act has opportunities to increase access to field-based outreach and linkage to services. There are also opportunities for staff training on evidence-based practices as well as billing and documentation. Medication-Assisted Treatment has also been added to the programs in Orange County. Another opportunity is increased collaboration for coordinated care between providers.

The committee engaged the presenters in a question-and-answer session upon conclusion of the presentation. The following key points were discussed:

- Committee members discussed potential reasons for a limited workforce such as providers leaving the field of behavioral health, older providers retiring from the field, and low reimbursement rates in the county system compared to private companies.
- A committee member asked about the licensing process for Full-Service Partnerships. The presenters shared that individuals with co-occurring disorders would still need a mental health diagnosis to qualify for Full-Service Partnerships under the Mental Health Plan Certification.
- Committee members discussed the use of Assertive Community Treatment as a service closer to the medical model in comparison to the original Full-Service Partnership model.
- There was a question on whether Orange County has a sobering center where law enforcement may take individuals to instead of carceral settings. The presenters shared there is one sobering station and law enforcement can drop the individual to the campus. The staff at the sobering centers then work with the individual to place them in the correct level of care if they accept treatment.

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

Item #7 Public Comment

Steve McNally from Orange County stated that making the system operate efficiently is important. He stated that it would help to make clients be seen as customers. CalOptima serves the mild to moderate and severe behavioral health populations. Steve emphasized the importance of communication and finding better ways to make legislators understand the system.

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 April 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 – April 2025

TAB 2

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, April 17, 2025

Agenda Item: Overview of the California Semi-Statewide Electronic Health Records System

Enclosures: Dawn Kaiser Professional Biography
The California Behavioral Health Semi-Statewide Electronic Health Record One-Pager
California Mental Health Services Authority Semi-Statewide Electronic Health Record Update Presentation. *For a copy of this document, please contact Ashneek.Nanua@cbhpc.dhcs.ca.gov.*

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 California Semi-Statewide Electronic Health Records System. The committee will use this information to help inform policy relating to the communication, coordination, and access to health information for individuals living with mental health and substance use disorder conditions.

Background/Description:

The California Mental Health Services Authority (CalMHSA) brought 25 counties together to implement a Semi-Statewide Electronic Health Record (EHR), which is a step toward creating a vision of wholistic county behavioral health data aggregation and interoperability. The Electronic Health Record has the primary purpose of improving the lives of Californians who receive care from county behavioral health departments.

Dawn Kaiser, the Senior Director of Analytics and Insights at the California Mental Health Services Authority (CalMHSA), will present an overview of the California Semi-Statewide Electronic Health Records System. The presentation will include information on the positive impacts and challenges associated with the Electronic Health Record, interoperability considerations (sharing information between county and hospital systems), and whether there is a difference in how the health record is used for inpatient and outpatient populations. Additionally, the presenter will discuss if the Electronic Health Record captures outcomes data for all funding categories and discuss

the process of how the California Mental Health Services Authority works with state requirements and the counties' implementation of the system.

The committee will have time to ask questions after the presentation.

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CalMHSA.org

Dawn Kaiser, LCSW, CPHQ

Senior Director, Analytics & Insights
California Mental Health Services Authority

Dawn Kaiser is Senior Director, Analytics & Insights for the California Mental Health Services Authority (CalMHSA), where she directs the organization's work to support county behavioral health plans through data analytics, research and evaluation activities.

CalMHSA is a state government entity that works to advance the public behavioral health system by creating technical solutions, operational innovations, training and statewide prevention campaigns for counties. Dawn has been instrumental in CalMHSA's initiatives to support counties on a wide range of projects, including reporting and dashboarding of CalMHSA SmartCare EHR data and technical support on performance improvement projects, External Quality Review Audits and delegated managed care responsibilities. She leads a multi-disciplinary team comprised of epidemiologists, technical and data analytic staff, and quality improvement professionals that brings clarity to critical operational questions through the use of research, statistical analysis, data modeling and visualization.

Previously, Dawn was Santa Clara County's Behavioral Health Plan Director of Quality Management, where she was responsible for strategy, planning and alignment of plan quality functions and performance improvement. She also served as Division Director of Quality Management for Marin County Behavioral Health and Recovery Services, with responsibility for the quality management, information technology and the 24/7 Access Team. Prior to that she was a Lead Reviewer for the APS Healthcare External Quality Review Organization, providing external quality review of Medi-Cal Mental Health Plans, and she worked in project coordination roles for University of California San Francisco's Department of Psychiatry mental health outcomes research projects.

Dawn earned a master's in social work from the University of Wisconsin-Madison and is a Licensed Clinical Social Worker, as well as a Certified Professional in Healthcare Quality.

TAB 3

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, April 17, 2025

Agenda Item: County Perspectives of the California Semi-Statewide Electronic Health Records System

Enclosures: Placer County Semi-Statewide Electronic Health Record 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 large county and small county's insights for implementing the California Semi-Statewide Electronic Health Records System. The committee will use this information to help inform policy relating to the communication, coordination, and access to health information for individuals living with mental health and substance use disorder conditions.

Background/Description:

Ryan Quist, the Behavioral Health Director for Sacramento County, will present the large county perspective of implementing the California Semi-Statewide Electronic Health Records System. Julia Soto, the Quality Management (QM) Program Manager for Placer County Health and Human Services, will provide the small county perspective of implementing the California Semi-Statewide Electronic Health Records System.

The presentations will include an overview of how the Semi-Statewide Electronic Health Record is used in each county as well as the challenges and opportunities of using the Electronic Health Record. The presentations will be inclusive of mental health and substance use disorder services systems of care. The committee will have time to ask questions after the presentation.

Presenter Biographies

Ryan Quist, Ph.D., Behavioral Health Director for Sacramento County Behavioral Health Services Department

Ryan Quist, Ph.D., is the Behavioral Health Director in Sacramento County. His work in Behavioral Health started in Riverside County Behavioral Health where he worked in various roles dedicating more than 20 years to County Behavioral Health.

He remains very active in Statewide advocacy on Behavioral Health topics and was elected by other Behavioral Health Directors as President for the County Behavioral Health Directors Association (CBHDA) for 2023 and 2024. He co-chairs the CBHDA Medi-Cal Policy Committee. He was selected to participate in the CalAIM Behavioral Health Stakeholder workgroup and contributed to planning for the various Behavioral Health CalAIM initiatives now being implemented.

In Sacramento County, his focus is on mental health and substance use services for the homeless population, criminal justice population, and bolstering the crisis continuum of care to prevent psychiatric hospitalizations. For children's services, he is dedicated to promoting field-based and school-based services and collaborating to support the foster youth and probation populations.

Julia Soto, MSW, LCSW, Quality Management (QM) Program Manager, Placer County Health and Human Services

Julia is the Program Manager for Quality Management and Behavioral Health Services Act (BHSA) for the Adult and Children's Systems of Care in Placer County. Her Programs provide oversight, quality assurance, evaluation and outcomes for the Placer Mental Health Plan and Placer Drug Medi-Cal Organized Delivery System, as well as the Placer In Home Supportive Services program. Julia completed her undergraduate and graduate education at the California State University San Bernardino, where she earned a Bachelor of Arts in Sociology as well as a Master in Social Work. Julia began her career providing direct services in a variety of settings in southern California. In 2013 Julia relocated to the greater Sacramento area. She joined the Placer County team in 2014 where she has taken on a variety of positions advancing her career into leadership and has been a program manager since 2020.

COUNTY OF Placer®

Semi-Statewide EHR

A medium County Experience

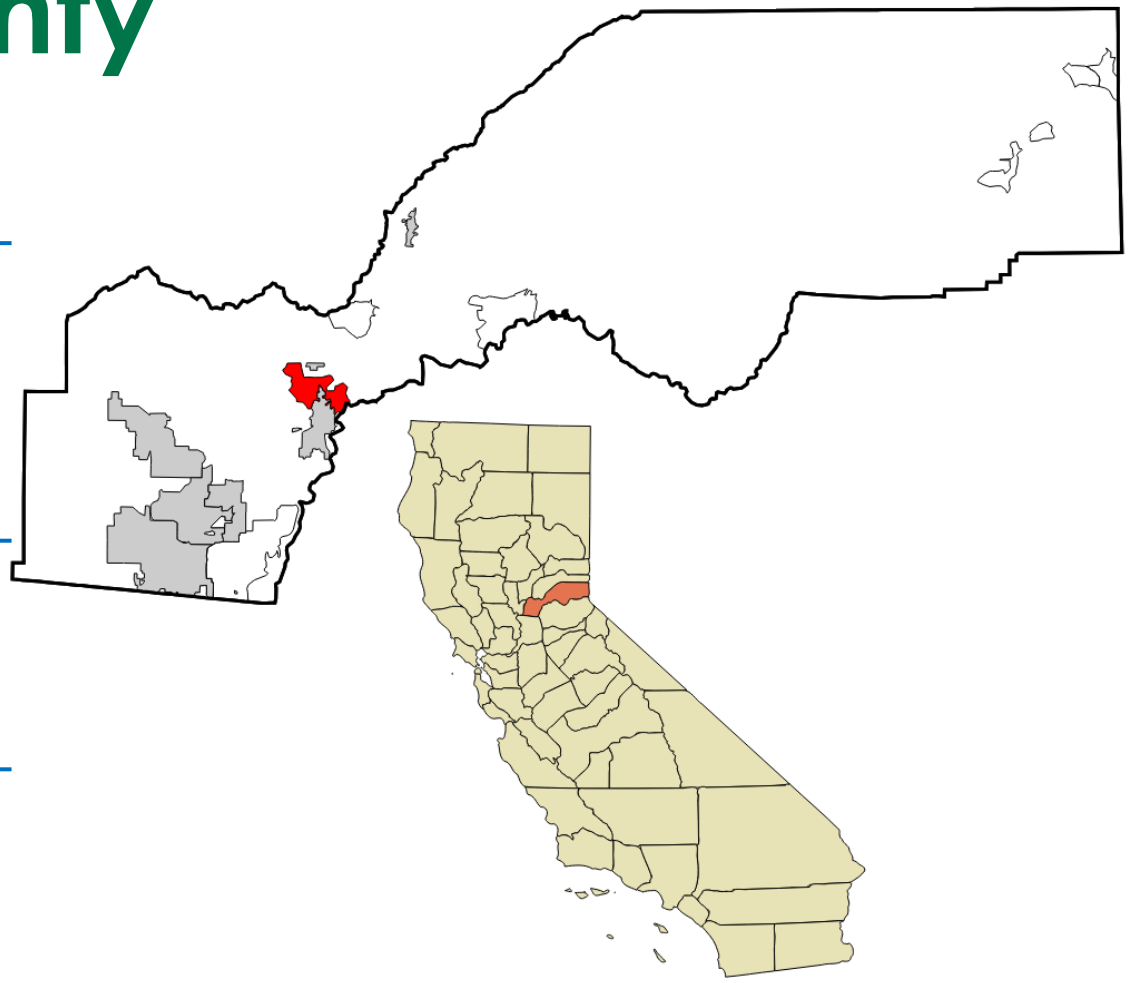
Placer County

Geographic area: 1,502 square miles

Boarders stretch from the suburbs of Sacramento to Lake Tahoe and the Nevada state border.

69% of the population live in the western 1/3 of the county

30% of the population span the eastern 2/3 of the from Auburn (RED on the map- population 13,737) to Tahoe/Truckee (population 2,589).



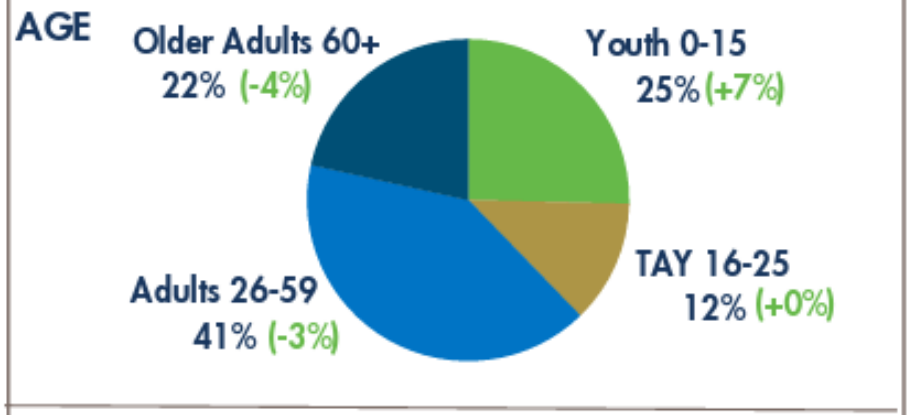
COUNTY OF Placer®

Placer County Stats

POPULATION

Population Estimate for Placer County as of 7/01/2023:
427,738

DEMOGRAPHICS



POPULATION CHANGE

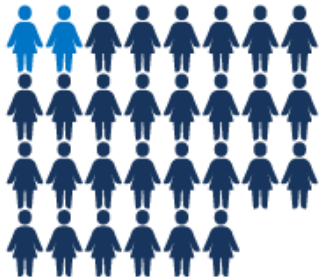
2020 to 2023:
3.75%

VETERANS

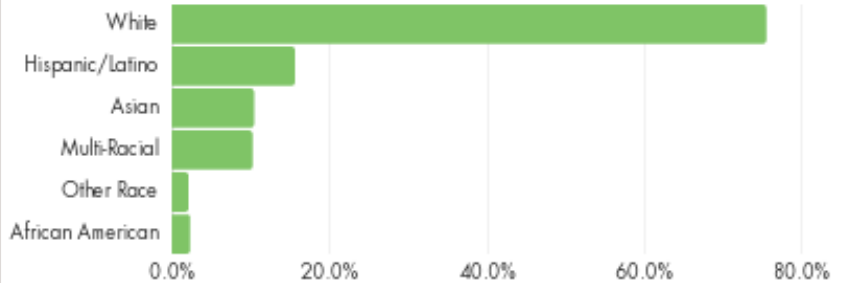
6.2%

LIVING IN POVERTY

6.8%



RACE



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BHP Network Characteristics

County Clinics

- Adult (MH/SUD) – 2
  Auburn & Cirby Hills
  Outpatient Clinics
- Children (MH) – 2
  Auburn & Sunset
  Outpatient Clinics
- SOC (MH) –1
  Carnelian Bay
  Outpatient Clinic

Contracted Providers

- DMC-ODS- 7
  (25 locations)
- MHP- 15
  (21 locations)
- MHP FFS- 14

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EHR Overview

Went Live 7/1/2023

9 of 22 network providers onboarded with us!

650 Users

300 staff use SmartCare for clinical documentation

Inpatient & residential providers do not use SmartCare*

*Other users upload state reporting and/or claims

County of Placer

EHR Early Adoption

- Going live early allowed us to avoid necessary updates to our former EHR, Avatar, with CalAIM and interoperability requirements twice.
- Going live early also meant going through the growing pains of a new system while also navigating payment reform.
- In addition to adopting a new EHR, we also contracted with CalMHSA to support our revenue cycle process and DQM process.

Opportunities

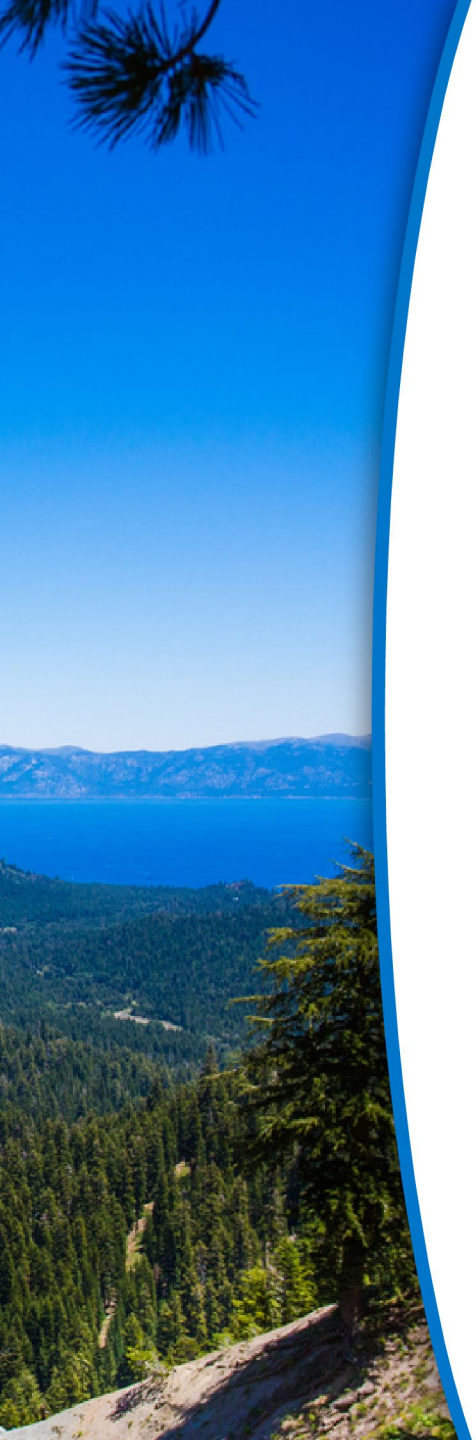
- Clinical Implementation and Monitoring
- Administrative and Technical Capacity
- Eligibility
- QI/QA support
- Billing & DQM Reporting
- Advocacy
- Interoperability

Local Successes: Clinical

- CalAIM documentation standards met (Progress notes, care plans, tx plans, problem lists, assessment).
- Clinical desk guides created and provided by CalMHSA
- DHCS required screening and transition tools with tracking and reporting included.
- Ability to use meta tagging for special populations.
- Productivity reports created in consistent manner.

Local Success: Program Set up

- Program set up is completed by CalMHSA to include enrollment in uniform service codes, state reporting, and provider directory, 274.
- Staff are assigned universal roles and permissions.
- Current and future statewide programs, service codes, data requirements will be automatically created, tested and deployed.



Local Successes: Eligibility

- Automated import of the MMEF (Medi-Cal Master Eligibility File) into the EHR
- 270/271 real time eligibility data allows **all** staff to check client eligibility.
- Active management of client and program payors allow for maximization of funding and easier tracking of funds spent per payor.

Local Successes: QI/QA

- Collection and formatting of state reports (almost all of them)
- Implementation of new mandates like 24/7 Mobile Crisis and Care Court.
- EQR Support
- BI dashboarding/reports provided by CalMHSA for monitoring and clinical use.

Billing

- Implemented Medicare billing! Estimated 80K annually increased revenue.
- Future billing code/service codes maintained by CalMHSA.
- Rate changes updated automatically.
- Reduced Medi-Cal denial rates, increased revenue.
  - More accurate DQM reporting

Provider Network and Interoperability

- System meets federal interoperability standards.
- Allows for interoperability solutions to be applied to provider network via CONNEX by CalMHSA.
- Allows for staff to share and view clients full chart
- Allows for efficient auditing and monitoring of charts (reduces administrative burden on provider and county staff).

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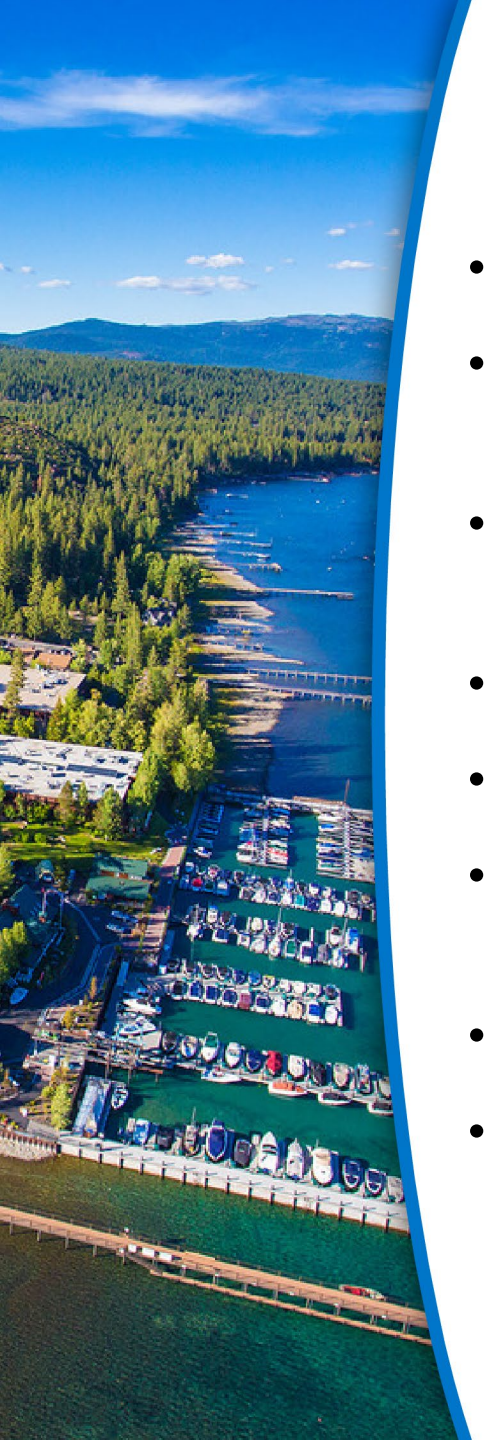
Advocacy Successes

- CalMHSA had access to data to analyze state proposed bundled rates based on actual billing data across counties.
- CalMHSA was able to get DHCS approval on forms and state reporting because they represented so many counties
- EQRO and Audit support



Challenges

- Technical staff struggle with loss of local control.
- Causes delay with establishing workflows, testing, and deploying new functionality.
- Local staff desire to validate reporting which reduces the efficiencies of system.
- Authorization system challenges
- MHSA reporting not yet functional
- Medical team not happy, designed more for clinician. Struggle with labs, etc.
- Can't pull up multiple screens
- Leading staff change while experiencing rapid change

Summary

Placer County improved on many measures on the accountability dashboards AFTER implementation.

We are achieving higher revenues. In part due to payment reform, but also due to decreased denials, increased billables, and efficiencies gained.

Being an early adopter of a new, not fully ready product has not been easy. Managing this change for our staff while implementing many new state initiatives was difficult.

Overall, the increased revenue and help from CalMHSA in Audits and with new program implementation has allowed our team to focus more on quality and less strictly on compliance.

All of this and the statewide advocacy have made this change worth it to Placer.

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Questions?

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TAB 4

California Behavioral Health Planning Council
Systems and Medicaid Committee

Thursday, April 17, 2025

Agenda Item: Adult and Children's System of Care Provider Perspectives of the California Semi-Statewide Electronic Health Records System

Enclosures: Turning Point Community Programs Presentation: SmartCare Electronic Health Record Challenges and Opportunities (*For a copy of this document, please contact Ashneek.Nanua@cbhpc.dhcs.ca.gov.)*

Stanford Sierra Youth and Families Presentation: Provider Perspective

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 the adult and children's system of care provider insights for the implementation of the California Semi-Statewide Electronic Health Records System. The committee will use this information to help inform policy relating to the communication, coordination, and access to health information for adults and children living with mental health and substance use conditions.

Background/Description:

Diana White, the Chief Executive Officer, Turning Point Community Programs will present the adult system of care provider perspective of implementing the California Semi-Statewide Electronic Health Records System. Laura Heintz, Chief Executive Officer, Stanford Sierra Youth and Families will provide the children's system of care provider perspective of implementing the California Semi-Statewide Electronic Health Records System.

The presenters will discuss how their organizations are navigating data entry for multiple counties and whether the Semi-Statewide Electronic Health Record has made an impact on training, submitting information to the state, and creating efficiencies for providers. The presentations will also include the challenges and opportunities of using the Semi-Statewide Electronic Health Record. The committee will have time to ask questions after the presentation.

Presenter Biographies

Diana White, President and Chief Executive Officer, Turning Point Community Programs

Diana White is the President and Chief Executive Officer for Turning Point Community Programs, a Non-Profit Community Based Organization providing behavioral health services in nine California Counties. She holds a PhD in Infant and Early Childhood Development with a specialization in mental health and developmental disorders. She has a master's degree in psychology and is a Licensed Marriage and Family Therapist (LMFT) and a Licensed Professional Clinical Counselor (LPCC). Diana is a Leadership Fellow with the Sierra Health Foundation and has worked in the mental health field for over 30 years. Diana served as President of the Association of Behavioral Health Contractors for Sacramento County from 2018-2023. She has taught graduate level courses in Trauma Treatment and Community Mental Health at Alliant University.

Dr. Laura Heintz, Chief Executive Officer, Stanford Sierra Youth and Families

For over 30 years, Dr. Heintz has worked tirelessly to help nonprofit health and human service organizations grow and expand their ability to serve children and families.

Over the years, Dr. Heintz has served a variety of programs with a focus on implementing services that meet the needs of young people and their families. She started her years of service in the field as a residential treatment counselor, then an in-home behavioral support counselor, then as a social worker, earned her doctoral degree while supervising programs and developed several new programs.

Professional accomplishments include having been a contributing author for the textbook Assessing and Treating Youth Exposed to Traumatic Stress - Stanford University – 2019, selected as a recipient of the Sacramento Business Journal Women Who Mean Business award in 2019, named CWLA Champion for Children 2020, and founded the Yolo Crisis Nursery in 2001- a child abuse prevention program.

A native Sacramentan, Dr. Heintz holds a Doctorate in Psychology, a Masters in Holistic Studies and a double BA in Human Development and Psychology. She is also a Certified Executive Coach. When asked why she is passionate about the mission of SSYF, Laura responded, "My work is my life calling. I am committed to my core in ensuring that those we serve know that they belong. We preserve family whenever possible. We support youth and families in their recovery from trauma and equip them so that they can thrive."

Utilization of the Semi Statewide EHR – Streamline SmartCare

Provider Perspective

Stanford Sierra Youth & Families

Dr. Laura Heintz

Chief Executive Officer of Stanford Sierra Youth & Families since 2012

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Agenda – Provider Perspective

- Agency Information
- Agency EHR
- County EHRs
- Training
- Efficiencies
- Challenges
- Opportunities

Stanford Sierra Youth & Families

- Founded in 1900 in Sacramento County– Stanford Home for Children
- Celebrating our 125th year
- Transformed over the years from an orphanage to a full continuum of services for young people and their families
- Providing community based mental health treatment, juvenile justice intervention, substance use prevention and treatment & child welfare services across several counties all of which are strength based, youth and family centered.

Who are we?

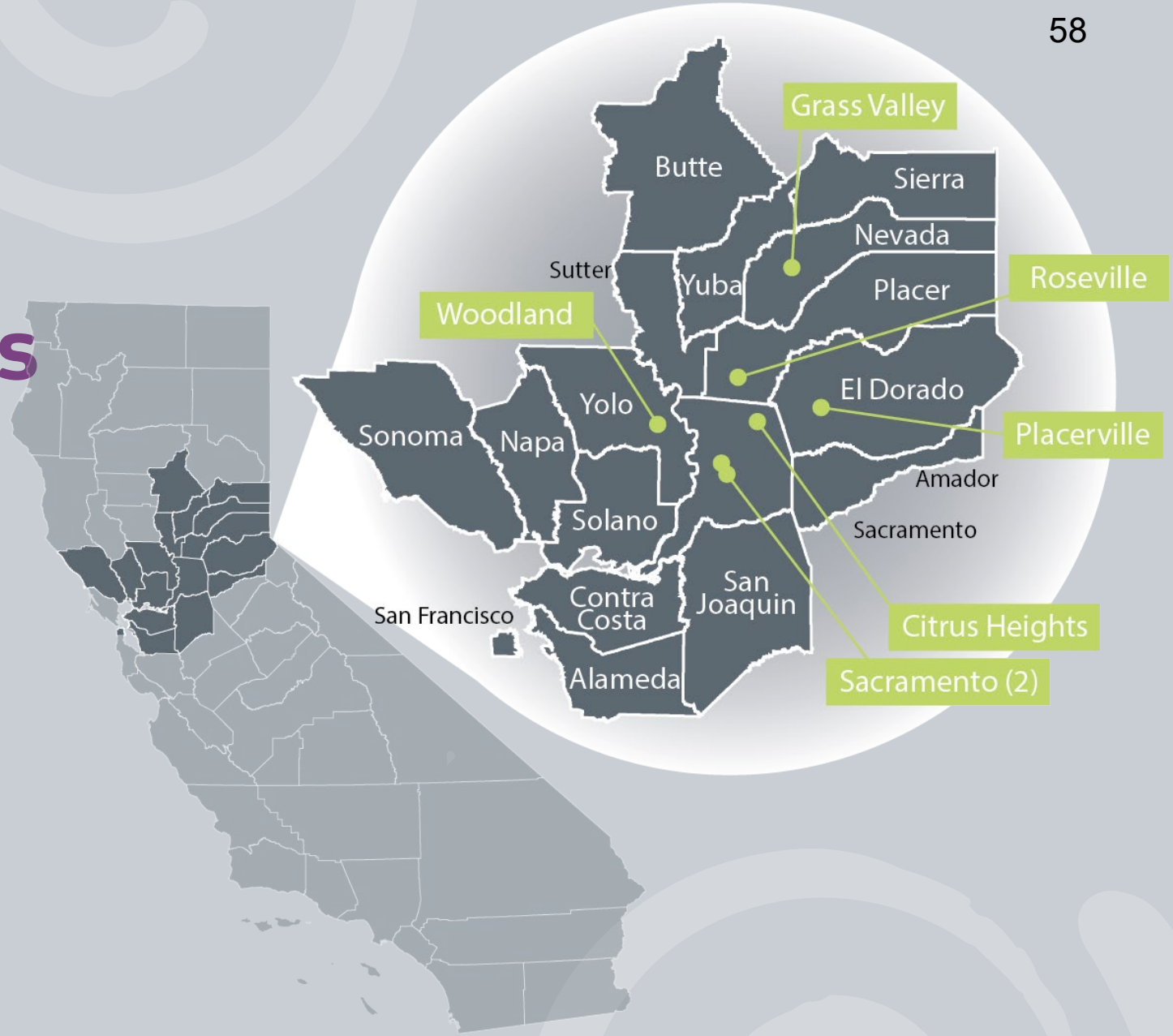
We provide a continuum of care to empower youth and families to overcome challenges together, and we connect youth in foster care to permanent families.

Mission: Transforming lives by nurturing permanent connections and empowering families to solve challenges together, so every young person can thrive.

Vision: Our communities have safe, lifelong connections for all young people, built and strengthened through generations of empowered families.

Values: Compassion, Equity, Excellence, Honor, Integrity, Partnership

FY 24/25
8,000 youth and their family members throughout Northern California

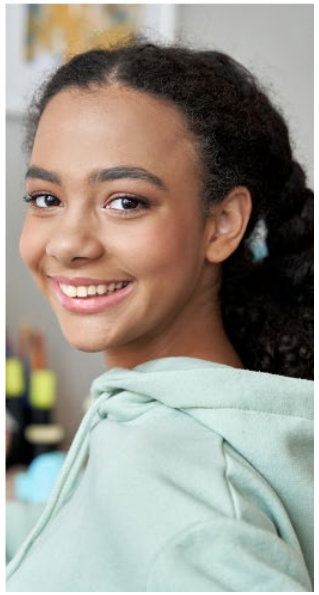


30+ Counties Served

6 Physical Locations

34 Programs

Stanford Sierra Youth & Families



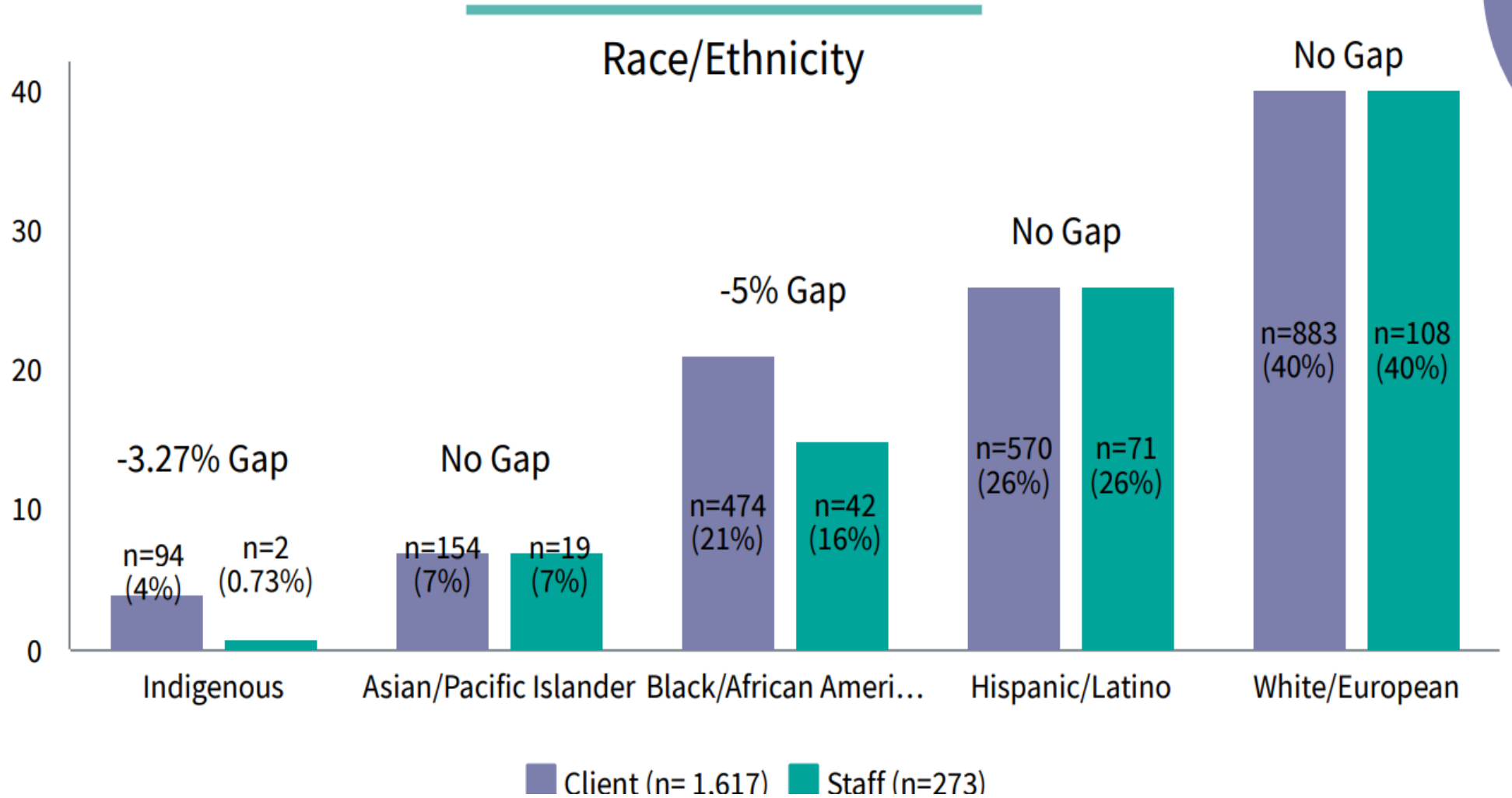
Mitigation of Unconscious Bias

Agency wide - Cultural competency training, culture brokers and cultural insight activities

- **Collaborative documentation practices-** focusing on writing documentation with the family/youth to ensure their voice is heard and documentation supports their experiences in treatment.
- **Standardized documentation practices**- we focus on objective and clinically relevant information and avoid using non- mental health relevant details that could introduce bias where appropriate.
- **Strength-Based** - Approach documentation and assessments through a strength-based lens.
- **Continuous Quality Improvement** -Engage in regular internal and external audits and feedback to review documentation and ensure appropriate standards and client care are met.
- **Family & Youth Partnership** – Every youth and family has the opportunity to work with peer support team members with lived experience

Staff to Client Comparison - All Agency

All Agency includes all staff members in program, administration and leadership



The **negative percentage** reflects **the gap** between staff and clients, indicating that there are **less staff** in the affected category.

Less than 1% (n=8) of clients and 6% (n=16) of staff declined to respond/did not know

5% (n=15) of staff chose **more than one race/ethnicity,** with a difference of 17% when compared to 22% (n=484) of clients who selected more than one race/ethnicity

Provider Perspective Questions

Semi-Statewide EHR Streamline SmartCare

- *How is your organization navigating data entry for multiple counties?* **Continued administrative burdens and challenges**
- *Has the EHR made it easier?* **Not all counties use the same EHR; Need to maintain our own to navigate differing demands.**
- *What is the impact for training and submitting information to the state?* **Year 1 challenged with different roll outs, messaging & State changes mid year. Year 2 is smoother.**
- *Are there efficiencies for the providers?* – **Yes, where applicable.**
- *What are the challenges and opportunities?* – ***Identified and will share.***

Received PATH funding for CalAIM readiness:
Lessons from TA Marketplace - Consultant's Assessment

- To be able to grow, adjust to County partners requirements and best serve community, we continue to ***need our own EHR***
- Capacity for ***Interoperability*** is critically important for the future- efficiencies
- Identified Additional IT Systems to connect with other partners (internal or external EHR)
  - *Integration with Fiscal & Timekeeping & Mileage*
  - *Need a Data Warehouse for Quality Improvement*

EHR Needs from Provider with Multiple Counties

- A Complete EHR to have access to all data and ensure quality
- Clinical Workflow
  - Intake/Assessments/Progress Notes/Discharges
  - Report generation for supervision & quality assurance
- HIPAA Compliance
- Revenue Cycle Management (Billing)
- Foster Care Module
- ePrescribing
- Web-based
- Patient/Client Portal
- Role-based & Program based Security Settings
- Flexibility to Accommodate Unique Programs

County
Electronic Record Requirements & Training

- Counties are utilizing different EHRs; and they are in different phases of implementation
- Maintained our own EHR where possible: Sacramento County, El Dorado County, Yolo County, Placer County
- Nevada County requires direct input in Streamline SmartCare
- Napa required that we transfer to Credible in 2024.
  - Challenged because we shared staff across Yolo and Napa
  - Napa will be transitioning to Streamline SmartCare in the Fall of 2025

* **<u>All counties with EHR require training at onboarding</u>**

SmartCare Efficiencies & Positives

- **Referrals:** automatically access referral notes about attempts to contact a family and then add information into the same record. That's been a streamlining of the referral process.
- **Real Time:** immediately see notes entered by other providers when a family has signed the release that takes down the "wall" between providers in SmartCare.
- **Intuitive:** Once you get familiar with how to search, it's easy to hop between documents.
- **Updates:** The ability to update the care plan and problem list from within the note itself is a plus
- **CANS**: The ability to see what you previously rated CANS when updating the CANS is a plus
- **Efficient Paperwork:** The discharge paperwork is efficient. Families sign consents directly in the system.
- **Individualized Information:** Ability to send out details that apply to each participant in the **group** to their individual note and then adjust for that specific participant.

SmartCare Challenges

Less Documentation Oversight from Provider- staff member submits directly in County system.

Assessments- when updating an assessment, it doesn't show last assessment's data.

Glitches- less frequently than at first, but still with some frequency.

Help- Getting help from the CALMHSA helpdesk is difficult.

Communication-When there is a change or an error there is limited to no communication –it appears communication is not centralized.

Reports- NONE for providers – including productivity

Stanford Sierra runs our own productivity reports. This is easier to do with our own EHR at this point.

Opportunities

- Consistency in documentation across counties would be amazing!
- Real time updates when State instructions change or are clarified could be possible!
  - Year 1 – extremely challenged with changes in instructions re: CPT codes, duration cut offs, and taxonomies
- Interoperability of EHRs county to provider and across systems would help with information sharing and case openings, reduce entry errors and reduce administrative burdens.

Thank you!

Comments/Questions

Laura Heintz

lheintz@ssyaf.org