ASOC Division Updates Behavioral Health Board Presentation

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

COUNTY OF MARIN

Jessica Diaz France, LCSW

9/8/2026

Agenda

1. Overview of Adult and Older Adult System of Care
2. BH-CONNECT and Behavioral Health Service Act (BHSA) Changes
   - Assertive Community Treatment/Forensic Community Treatment (ACT/FACT) Level of Care
   - Changes to Full-Service Partnership Programs Eligibility Criteria
3. Request for Proposal- Awardees and upcoming services
   - Individual Placements and Supports (IPS)
   - Clubhouse Services
   - Behavioral Health Bridge Housing (BHBH)
4. Questions

Adult and Older Adult Division Overview

- ASOC division serves people with Serious Mental Illness with moderate to severe functional impairments.
- Referrals into ASOC come primarily through Access team where they are screened and assessed by ASOC teams (non-urgent) and Access (urgent- e.g., hospital discharge).
- Insurance types: Marin County Medi-Cal, low-income uninsured, Medi-Medi.
- Services are delivered in office, home, field; wherever the client is and resides in Marin County.
- ASOC provides services through an array of county and contracted services including outpatient services, case management, psychotherapy and clinical services, housing, vocational/employment, residential (IMD) and peer services.
- Services provided in English, Spanish, Vietnamese and other languages utilizing Language Line interpreter and translation services.

Adult and Older Adult Division Overview

- Clinic locations:
  - 1682 Novato Blvd, Novato (ACT/FACT and Odyssey)
  - 10 North San Pedro, San Rafael (HOPE)
  - 3270 Kerner, San Rafael (BRIDGE Kerner, STAR, Residential Services)
  - 250 Bon Air Road, Greenbrae (BRIDGE Bon Air)
  - Services also provided at HHS West Marin (Point Reyes) and HHS Southern Marin Hub.
  - Residential Services Team travels throughout the region to meet clients in-person at residential IMD placements. Hospital Liaison coordinates care for Marin County Medi-Cal beneficiaries in inpatient hospital settings in the region.
- FY 26-25 ASOC worked with 1,596 clients.

Adult and Older Adult Division Overview

- Leadership:
  - Division Director: Jessica Diaz France, LCSW
  - Program Managers:
    - Tamara Hornsey, LCSW
      - *BRIDGE teams, contract management: Peers, Vocational/Employment Services and Eating Disorders*
    - Yazmin Saddler, LMFT
      - *ICM/FSP, ACT/FACT, Residential Team, residential contracts*
  - There are additional staff in ASOC who are teams of one- embedded Behavioral Health Practitioner (BHP) in CalWorks, Medi-Cal and Eligibility Specialist, Department of Rehabilitation part-time BHP, and Administrative Services Associate.

BH-CONNECT and Evidenced Based Practices

- **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)** initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. This expands coverage of evidenced based practices (EBPs) available under Medi-Cal.

- BHRS/ASOC has opted into the following EBPs:
  - **Assertive Community Treatment**
  - **Forensic Community Treatment**
  - **Individual Placements and Supports**
  - **Clubhouse Services**

BH-CONNECT Changes

How services are delivered:

- New service delivery model ACT/FACTv
- ASOC went from two levels of outpatient care to three:
  - BRIDGE
  - Full-Service Partnership Teams become Intensive Case Management Teams
  - ACT/FACT

New services available:

- All ASOC clients will have access to new vocational services delivered in the IPS model.

New Medi-Cal billing structure:

- Empowerment Clubhouse will have the ability to bill a new day-rate for clients engaged there which represents a new revenue opportunity for CBO.

DHCS and Center of Excellence

- Under the Behavioral Health Services Act (BHSA), county Full-Service Partnership (FSP) programs are required to have two levels of coordinated care for BHSA eligible adults and older adults: Assertive Community Treatment (ACT/FACT), a stand-alone EBP as the highest intensity level, and FSP Intensive Case Management (ICM), which can be a standardized step-down level from ACT or provided to individuals requiring a lower level of care than ACT.
- BHSA has renamed Full-Service Partnership Programs: Intensive Case Management or ICM Teams.
- Each Evidenced Based Practice (ACT/FACT, IPS, Empowerment) has a Center for Excellence, guiding counties and service providers on best practices, training, and eventually fidelity scoring. ASOC leadership and CBO's are engaged in monthly meetings and are using on-demand learning systems.

ACT/FACT & ICM

- ACT is designed for individuals living with complex and significant behavioral health needs who require frequent, intensive, and community-based services.
- Forensic ACT (FACT) extends this model to individuals who meet the service criteria and who are also involved in the criminal justice system.
- 2029 is the goal to get to fidelity to the model. We are in a ramp up phase with the support of the Center for Excellence at UCLA.
- ICM/FSP offers a comprehensive array of community-based services and can be provided either as a step-down from ACT or as an intervention to avert the need for ACT-level care.
- ICM/FSP is delivered by a multidisciplinary team that incorporates core case management functions—such as assessment, planning, and linkage—with assertive outreach, and direct service delivery.
- ICM/FSP is for individuals who may not meet ACT eligibility criteria but still have significant behavioral health needs and can benefit from FSP supports.

ACT/FACT

- As of July 1, ASOC has a new team and level of care: ACT/FACT.
  - Comprised of staff from two FSP teams IMPACT North and IMPACT South:
    - 1 Supervisor
    - 4 Behavioral Health Practitioners*
    - 2 Social Service Workers (1-SUD focus)
    - 2 Peer Specialists*
    - *Spanish bilingual capacity
  - Based out of 1682 Novato, however primarily field-based
  - Census made up of former IMPACT clients. Over time we will look at transfers between the levels of care to ensure client appropriateness to the model.
  - Goal is to have the least disruption to client care as possible, and transfers will occur as clinically indicated.

ACT and ICM: Key Differences

	Diagnosis	Functional Impairment	Continuous needs	Service Delivery
ACT/FACT	SMI; most will have a primary psychotic disorder; ACT is not appropriate for primary SUD	**Significant** functional impairment, persistent or recurrent failure to perform daily living tasks except with significant support	**High use** of psychiatric hospitalization or crisis services; legal system.	Crisis support 24 hours a day; ACT/FACT comparable to a "hospital outside the hospital"
ICM	SMI and may be co-occurring SUD	**Moderate to significant** functional impairment- may be consistently or occasionally; the individual experiences more stability most of the time.	**Risk of** hospitalization or crisis emergency care without this service. Does this individual have periods of greater stability but need a support network in place for when a period of acute instability occurs? If yes, they may be best served by FSP ICM.	Intensive community-based service
Both ACT/ICM	SMI		**Risk of** homelessness, criminal justice involvement, inability to participate in traditional office-based services.	Assessment, crisis intervention, medication support services, peer support, psychosocial rehab, referral linkages, therapy, treatment planning

- FSP Adult Levels of Care Comparison Chart

Eligibility Changes for ICM/FSP Teams

- Given the mandate is to create a new level of care: ACT/FACT, we had to create flexibility in the other levels of care in the division to be responsive to clients' needs and not create unnecessary barriers to care.
- FSP reduced their footprint from 5 teams to 3 ICM teams.
- Previously, FSP's were organized by specialty populations (homelessness/precariously housed, criminal justice involvement and age).
- Retaining previously utilized specialty populations in these teams would create challenges to match client to program.
  - e.g., What would happen for clients who are housed, no criminal justice involvement and 55 years old?
  - Historically, we have been challenged by unclear criteria when clients meet multiple special populations. This has created challenges with access to care, delays and clients thought to be "inappropriate" for the team they were assigned to.

Eligibility Changes

HOPE

- No significant changes; clients must be 60 years old to be eligible for the program.

Odyssey

- Homelessness and precariously housed no longer eligibility criteria for Odyssey.

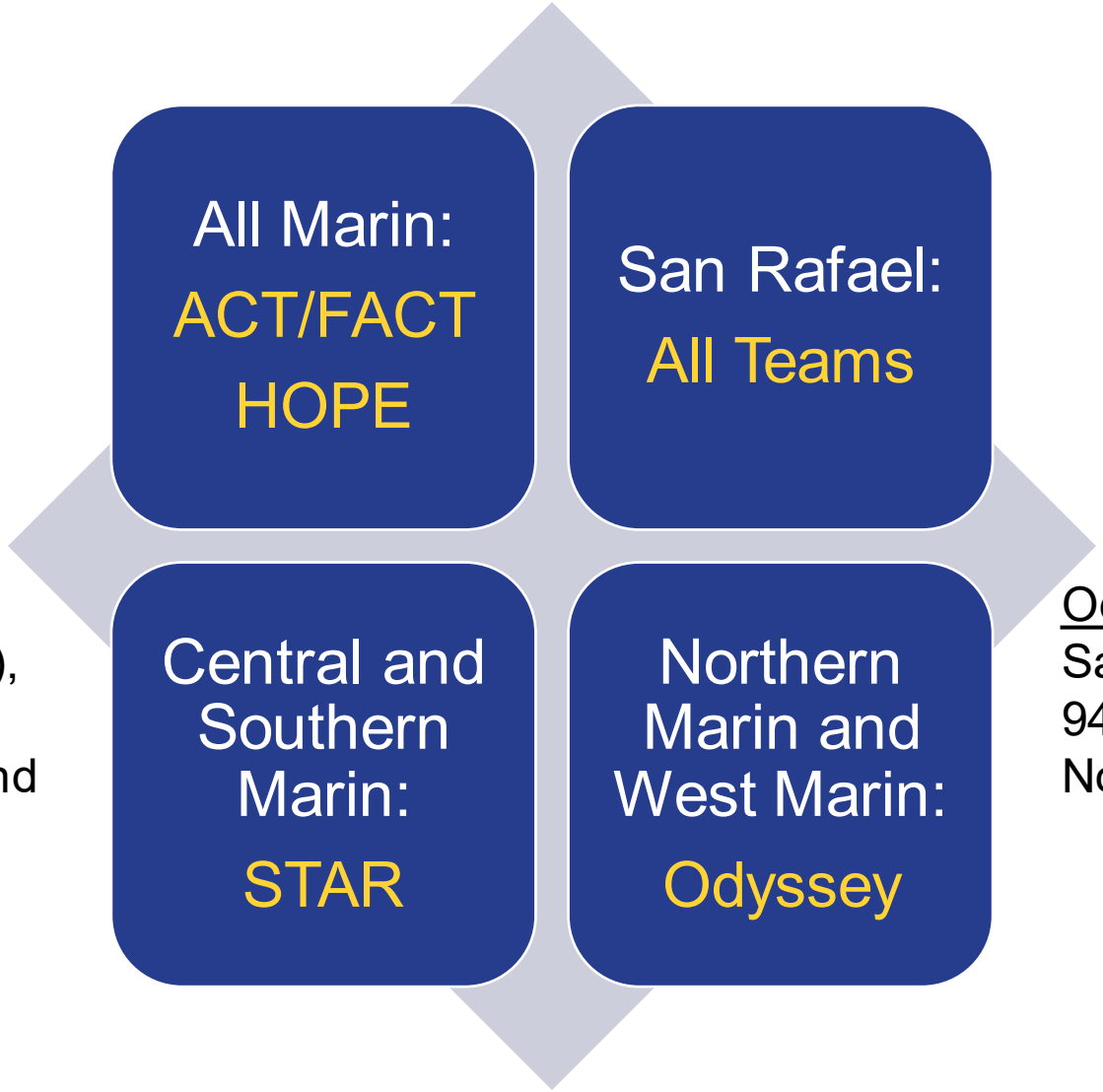
STAR

- Forensic and criminal justice involvement or history no longer eligibility criteria for STAR*.
- Jonathan's Place Team will move to STAR program October 2026

*STAR Court will remain a feature of the STAR team and has its own referral pathway.

Requests for disability accommodations may be made by phoning **415-473-2215** (Voice), CA Relay 711 or by e-mail at **Jessica.DiazFrance@marincounty.gov**

Client location and ICM Team Assignment



STAR (San Rafael)
San Rafael (94901), Central Marin, San Geronimo Valley and Southern Marin.

Odyssey (Novato)
San Rafael (94903 and 94901 area code), Novato, and West Marin.

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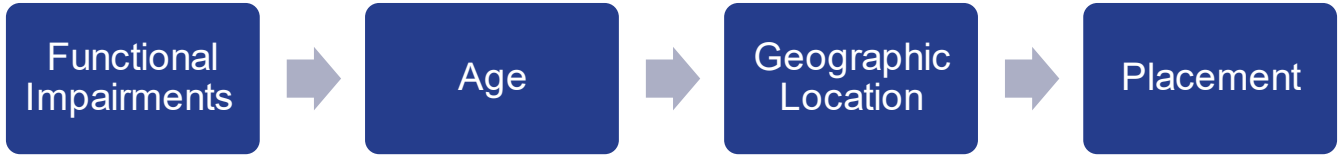
ICM Placement Decision Tree



- When a client meets ICM criteria and associated functional impairments for the level of care, we will first consider their age and then geographic location when determining placement.
  - 60 and older: **HOPE**
  - San Rafael, Novato, West Marin: **Odyssey**
  - San Rafel, Central Marin and Southern Marin: **STAR**
- The priority is to use this decision tree for new-admits to the division.
- Over time, we will can transfer clients to other ICM teams to align for age and location as clinically indicated/appropriate.

ASOC Division: 3 Levels of Care

ACT/FACT*

1 team

- ACT/FACT will be the highest level of care in the division, served by one team.

ICM/FSP

3 teams

- Intensive Case Management (ICM): Odyssey, HOPE and STAR.

BRIDGE

2 teams

- BRIDGE will remain two integrated teams- Bon Air and Kerner.

*Level of Care determinations made by Key Event Tracking (KET) data and LOCUS.

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Request for Proposals (RFP) Updates

- Buckelew Programs- awarded RFP for scattered site housing. This will add rental subsidies and supports for their RSS and MAIL housing programs.
- Ritter Center- awarded RFP for Individual Placement and Supports (IPS) services. IPS will serve 100 clients in the first year. Eligible clients will be connected to BHRS any level of care (17+).
- Enterprise Resource Center- awarded RFP for Drop-in Peer Services Center, there will be a new referral process for BRIDGE.
- Mental Health Association of San Francisco (MHASF)- awarded RFP for Family Partner Program, services for open BHRS client families, psychoeducation, groups.

Individual Placements and Supports (IPS)

- IPS is one of the Evidenced Based Practices that we are implementing as part of BH-CONNECT.
- Supports individuals with behavioral health needs in finding and keeping competitive employment
- Pillars of IPS:
  - Individualized Services:
    - Individual preferences, strengths, factors related to disability, living situation.
  - Team-based Services:
    - Connection between treatment team, vocactional team, families and support persons
  - Community Based Services:
    - IPS specialists spend most of their time in the field with clients and making relationships with potential employers

Individual Placements and Supports (IPS)

- Any BHRS clients can utilize IPS services, including SUD clients. Age is 17+.
- Employment linkage based on client interest, instead of training in a modified employment opportunity (e.g. training café).
- Zero exclusion - everyone who wants to work will work not just "work ready".
- IPS replaces the vocational services provided by Integrated Community Services (ICS).
    - ICS Independent Living Services (ILS) will continue for Odyssey, HOPE, and STAR. ACT/FACT will provide ILS services to their clients.

Clubhouse Services

- Clubhouses provide a safe, restorative recovery community
  - Inclusive, community-based spaces for individuals with behavioral health needs that support emotional, cognitive, and social skill-building
- Help members pursue employment, education, housing, and independence
- Members and staff work side-by-side as equals
- Offers meaningful work, supportive relationships, and social/recreational opportunities
- The daily activity of a Clubhouse is organized around a structured system known as the work-ordered day. Members and staff work side by side as colleagues to perform the work that is important to their community.
- Structured around the evidence-based Clubhouse Model

Clubhouse Services in Marin County

- Empowerment Clubhouse provides critical and essential workforce, mental health, and financial educational services to marginalized, low-income, and underserved communities.
- Programs – Youth, Workforce & Career Development, Construction Trades, Small Business Program, Digital Literacy, Department of Rehabilitation, Job Placement
- Priority regions served are Marin City, and include the Canal, West Marin, Novato, and LGBTQ+ communities.
- Able to serve Marin County residents 18+; they also have a youth program for ages15-18.
- Address: 441 Drake Avenue, Marin City/Sausalito

Facilities and Program Updates

- STAR Team Name: Support and Treatment After Release to be known as Support Treatment and Recovery Team. Name change to reflect expanded eligibility criteria moving forward.
- Southern Marin Annex/HHS Hub: 630 Drake Avenue, Marin City is now open. ASOC has use of the BHRS office on Tuesdays for drop-in use and client meetings. We are excited to make use of this beautiful new space and serve more clients in Southern Marin.
- Jonathan's Place Team will move to the STAR team in October. This includes one BHP-onsite provider of behavioral health services for 15 permanent supportive housing clients and part-time Peer. The peer position adds .5 FTE peer services to STAR clients. STAR lost peer support due to vacancy of a fixed-term position.
- BHRS Novato Clinic relocation to 350 Ignacio Blvd., Novato will be the future home of Odyssey and ACT/FACT teams; timeline is at least a year out as there are updates and construction needed for the space to be move-in ready.

Behavioral Health Bridge Housing (BHBH) Grant

- BHBH is available for BHRS clients who are homeless or at risk of losing housing. If not BHRS, must be SMI or suspected SMI and homeless.
- **Grant ends June 30, 2027.**
- Arrowood, Santa Rosa: Partnership with Sonoma County. 20 beds; temporary stay up to one year.
- Participation Assistance Funds: funding related to securing or maintaining housing when no other funds are available.
- Housing Navigation: any client that is connected to BHBH may have access to housing navigation. Arrowood clients are prioritized.
- There are three staff embedded in Homeless and Coordinated Care (HCC) division who can help secure housing supports and make a housing plan after Arrowood.
- Referral form: BHBH Referral Form