STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 03/25)

Fiscal Year	Business Unit Number	Department
2026-2027	4440	Department of State Hospitals

Hyperion Budget Request Name	Relevant Program or Subprogram
4440-052-BCP-2026-MR	4440 - Administration

Budget Request Title
Continuum Electronic Health Record System

Budget Request Summary
The Department of State Hospitals (DSH) requests $27.6 million General Fund in 2026-27 and a reappropriation of $6.3 million General Fund from 2025-26 to 2026-27 for a total of $33.8 million General Fund to fund the equivalent of 68.6 positions and to implement and support the organization's Continuum Electronic Health Record (EHR) solution for Site 1 of 5 and begin Site 2 and 3 implementation readiness activities. DSH also requests provisional language to allow the Department of Finance to appropriate additional General Fund, if needed, to meet the proposed EHR 2026-27 project schedule.

Requires Legislation (submit required legislation with the BCP)	Code Section(s) to be Added/Amended/Repealed
☐ Trailer Bill Language ☒ Budget Bill Language ☐ N/A	N/A

Does this BCP contain information technology (IT) components? ☒ Yes ☐ No *If yes, departmental Chief Information Officer must sign.*	Department CIO Chad Corrin	Date 5/14/2026

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), the approval date, and the total project cost.

Project No.4440-126 **Approval Date:** 6/24/2024

Project Approval Document: Stage 3 Approval Letter **Total Project Cost:** $460,356,107

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Lindsey Murphy	5/14/2026	Brandon Price	5/14/2026
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	5/14/2026	Kim Johnson	5/14/2026

Department of Finance Use Only

Additional Review: ☐ Capital Outlay ☐ ITCU ☐ FSCU ☐ OSAE ☐ Dept. of Technology

Principal Program Budget Analyst	Date submitted to the Legislature
Joseph Donaldson	5/14/2026

A. Problem Statement

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment for individuals with complex behavioral health needs in a safe, equitable, and responsible manner, by leading innovation and excellence across a continuum of care. The Office of the National Coordinator for Health Information Technology reports that, as of 2021, 96% of all non-federal acute care hospitals have adopted a certified Electronic Health Record (EHR). This marks a substantial increase from ten years earlier when that number was only 28%. Despite this progress, California remains one of the nine states without an EHR implementation in any State-run psychiatric hospitals, according to the 2019 National Association of State Mental Health Program Directors' (NASMHPD) research ally, the NASMHPD Research Institute (NRI). DSH continues to be reliant on antiquated, paper-based, medical record systems and obsolete disparate technology systems to chart patient care. The lack of an EHR increases the risk of compromised patient safety, organizational inefficiencies, and impedes collaboration with other healthcare providers and between patients and the healthcare personnel who treat them. This leads to challenges and potential errors in accurate diagnosis, treatment pathway selection, and medication administration. The absence of real-time data sharing increases the likelihood of medical errors, adverse drug interactions, and delayed interventions, all of which compromise patient and staff safety. In emergency situations, the lack of immediate access to comprehensive patient information can impede timely decision-making, exacerbating critical conditions and potentially endangering lives.

Currently, DSH does not have efficient processes to collect or analyze data related to patient treatment, medications, vital statistics etc. which can lead to negative patient treatment outcomes. DSH must implement a sustainable EHR solution across the organization's five facilities to maximize the provision of efficient and safe treatment services to all patients. Currently, DSH team members are relying entirely on a siloed mix of manual processes, outmoded legacy computer applications, and paper records to manage health information. These outdated processes of providing clinical care do not align with current industry best practice or satisfy the legal requirements that an EHR solution would provide.

An EHR solution presents an integrated approach reflecting DSH's vision of whole person care, developing standardized documentation and data collection with improved patient care coordination, diagnosis, and outcomes across the organization's various forensic populations. DSH intends to begin implementation of the EHR solution across early 2026.

At a high level, all DSH clinical and hospital operations require the following standard industry functionality in an EHR:

- Clinical documentation
- Computerized Provider Order Entry (CPOE)
- Electronic Medication Administration Records (eMAR)
- End-to-end pharmacy
- Lab reports
- Decision support
- Patient scheduling
- Electronic signature
- Data reports
- Data migration/interoperability
- Patient registration
- Coding and billing
- Security
- Regulatory compliance

Resource History

(Dollars in thousands)

Program Budget	PY – 4 (FY 20/21)	PY – 3 (FY 21/22)	PY – 2 (FY 22/23)	PY-1 (FY 23/24)	PY (FY 24/25)	CY (FY 25/26)
Authorized Expenditures	$2,425	$3,321	$8,483	$37,530[2]	$39,064[3]	$41,454[3]
Actual Expenditures[1]	$2,234	$5,401	$7,264	$23,842[4]	$27,317[5]	$10,463[8]
Authorized Positions	4.0	8.0	24.0	66.2	66.2	92.6
Filled Positions	4.0	8.0	10.0	38.9	38.9	62.2
Vacancies	0.0	0.0	1.0	27.3[6]	14.0[6]	30.4[7]

[1] Actual expenditure exceeded BCP authorized expenditures due to redirection of staff to assist project team throughout the planning phase.
[2] $7.2 million returned in FY 23/24 for medical devices and salary savings, original appropriation was $44.8 million.
[3] EHR BCP 5 reappropriated $7.5 million from FY 24/25 to FY 25/26. This adjusted FY 24/25's appropriation from 46.5 million to $39 million, and FY 25/26's appropriation from $34 million to $41.5 million.
[4] $5.3 million in outstanding encumbrances remain for FY 23/24.
[5] $2 million in outstanding encumbrances remain for FY 24/25.
[6] Vacancies are a result of adjusted project timelines and onboarding of these positions have been shifted to align with current project timelines.
[7] FY 25/26 vacancies include 26.4 positions authorized for FY 25/26 by BCP 5. Positions are in process of being filled, however, 16.4 of the authorized positions are due to be phased-in later in the year.
[8] $1.3 million in outstanding encumbrances remain as of mid-FY 25/26

B. Justification

To enable project success and mitigate risk of a project of this magnitude, requested state resources are aligned with projected project outcomes. The EHR project team, taking lessons learned from prior EHR implementations in other systems and in close collaboration with industry experts, adopted a sequential implementation approach for both project rollout and funding. DSH will be taking a measured approach by implementing a systemwide solution with one state hospital first, then expanding it to the other state hospitals. DSH requests the system integrator costs for the first site location only, DSH-Coalinga, and resources, equipment, and ancillary costs for DSH-Coalinga, DSH-Metropolitan and DSH-Atascadero in this proposal. DSH will align future resources, equipment, and ancillary costs after successful implementation at the remaining sites, DSH-Napa and DSH-Patton. DSH will work towards the development of a cohesive enterprise system and collect the data necessary via the first site implementation to reflect the most accurate cost estimates for the larger enterprise resources and equipment needed to complete implementation via a future proposal for the remaining two sites.

Funding from this proposal would support the actual EHR solution/software and key roles in clinical operations, service desk support, patient management, information security, service governance, legal and privacy, and administrative functions and aligns state and contract staff to be reflective of current and expected project needs for the first site implementation and to begin readiness activities at the second and third sites. The cost breakdown includes:

EHR System Integrator: $15,914,210 in FY 2026-27 (for DSH-Coalinga)

The EHR System Integrator will implement DSH's core EHR system with in-scope software systems and applications and will include system specific requirement planning, workflow configurations, training, and adoption methods. Ongoing software license and support costs are needed to continue the use and support of the EHR system post implementation at DSH-Coalinga.

Registry Staff Backfill: $5,674,100 in FY 2026-27(for DSH-Coalinga and DSH-Metropolitan)

DSH hospital staff will need to be trained on the EHR system before the system is implemented and can be used in direct patient care. This training will take staff away from their normal patient care duties. Continuity of patient care is imperative to allow the hospitals to meet level of care staffing minimums. This funding represents costs associated with backfilling behind level of care staff who would be conducting training in lieu of their regular unit/patient care work. The staffing need will be achieved through overtime and contracted staff to allow sufficient time for EHR-related training.

Interagency Consultancy: $282,000 in FY 2026-27

The EHR Project receives oversight from CDT in the areas of PAL, Independent Project Oversight (IPO) consultancy. As determined by CDT, critical partners are also called upon for review as necessary from other sections of CDT such as Office of Enterprise Architect (OEA) and Statewide Technology Procurement (STP).

End User Devices: $3,885,100 and Medical Devices: $1,117,000 (for DSH-Coalinga, DSH-Metropolitan, and DSH-Atascadero)

To prepare and receive maximum benefit from an EHR solution, additional devices will need to be deployed at DSH-Coalinga, DSH-Metropolitan and DSH-Atascadero including tablets (which would be used for documentation by staff providing one-to-one observation of patients who have exhibited self-harm behaviors or ideation), laptops (used to enhance access by nursing staff who document weekly progress notes on all patients when workstations are unavailable), mobile devices, scanners (used to complete electronic medication administration recording), workstations, workstations on wheels (for point of care medical services), label printers, dictation devices (used by physicians and psychiatrists whose documentation workload increases upon implementation), and second monitors.

Security & Privacy Incident Response: $2M in FY 2026-27 and ongoing

The implementation of an EHR system requires a more robust security and privacy incident response program including zero trust and Multi-Factor Authentication (MFA) for all machines in the secure treatment area. Implementation of zero-trust elements will align DSH with State and Federal guidelines for identity management. Elements include expansion of DSH Hub platform to include security and privacy incident handling capabilities, automation within DSH security monitoring infrastructure allowing automated resolution of security risks, and phish-resistant password less authentication mechanisms, mitigating the risk of user credential theft.

Provisional Language

The above contracts and associated amounts assume an aggressive implementation schedule established by the vendor to implement the EHR at DSH-Coalinga in the BY and begin readiness activities for DSH-Metropolitan and DSH-Atascadero. Provisional Budget Bill Language is requested to allow Department of Finance to appropriate additional funding, after 30 days written notification to Chairperson of the Joint Legislative Budget Committee, or a lesser period if requested by the department and approved by the

chairperson or the chairperson's designee, for these items as needed should the full costs reflected above to maintain this schedule materialize.

C. Departmentwide and Statewide Considerations

DSH currently relies on outdated mainframe, manual paper-based charting and technical infrastructure which poses significant challenges in maintaining and supporting critical treatment operations. The longer DSH goes without an EHR and relies on these outdated legacy systems, the more risk of negative patient outcomes and unrecoverable system outages, and further misalignment with evolving state and federal healthcare data requirements. This outdated infrastructure hinders efficiency, jeopardizes patient safety, and impedes the delivery of quality care.

Maintaining legacy mainframe systems requires specialized skills that are increasingly scarce and costly to retain, increasing resource constraints and operational inefficiencies. Examples of these systems include Admission, Discharge, and Transfer System (ADT), which houses not only patient demographics but also serves as the single source for their behavioral health and medical diagnostic history. Another example is Pharmacy Hospitals Operations (PHO), which serves as the single source for storing patients' medical orders, including all medications. These systems have already aged beyond their useful life, and they no longer meet the operational needs of the Department. As time goes by these systems become challenging to add to or change, are increasingly difficult to maintain, and DSH cannot retain staff due to retirement that have the appropriate knowledge and expertise to maintain mainframe applications due to retirements. Contractor engineers who have the required skillset to keep these systems operational are also extremely difficult to find. If these legacy systems are not replaced before they become impossible to maintain, there is substantial risk they will collapse. In the event of a mainframe collapse, clinicians would not have immediate access to patients' current diagnoses, treatment plans and medication orders, resulting in unacceptable delays and severe degradation of services.

Manual data entry and paper-based workflows drain valuable time and resources, diverting attention away from patient care and impeding staff productivity, leading to inefficiencies in information retrieval, data analysis and documentation, which increases administrative burdens across the Department. These delay billing cycles, introduce, reimbursement challenges, and lead to financial losses that compound over time.

Without an EHR, accessing patient records becomes cumbersome and time-consuming. This leads to challenges and potential errors in accurate diagnosis, treatment pathway selection, and medication administration. The absence of real-time data sharing increases the likelihood of medical errors, adverse drug interactions, and delayed interventions, all of which compromise patient and staff safety. In emergency situations, the lack of immediate access to comprehensive patient information can impede timely decision-making, exacerbating critical conditions and potentially endangering lives.

Beyond clinical an operational risk, failure to modernize jeopardizes DSH's ability to comply with statewide health data initiatives. California's Data Exchange Framework includes a requirement for secure and seamless data sharing across providers, payers, and government agencies. Without an EHR, DSH is not equipped to meet these interoperability standards. Additionally, equity-related reporting requirements from the California Department of Health Care Access and Information increasingly demand timely, standardized data to identify and address disparities in care delivery. The current fragmented systems can create future compliance and reputational risk.

Outcomes and Accountability

This proposal requests contract funding to allow DSH to successfully implement the EHR System, at DSH Coalinga to meet the five hospital requirements, and staffing requests at DSH-Coalinga, DSH-Metropolitan and DSH-Atascadero required to begin implementation readiness activities at and to begin maintenance and support. The implementation of an EHR system can be a complex process requiring a team of staff with specific skills and knowledge, which is critical to the success of the system's adoption.

The project will be organized and conducted to meet requirements of the SIMM, Section 19 under the guidance of the California Project Management Framework and the Project Management Body of Knowledge, as maintained by the Project Management Institute. CDT will be a critical partner in the effort providing oversight and IV&V of the process, including negotiation and award of the contracts.

Projected Outcomes

Several clinically based projected outcomes include improved patient safety and quality of care. Projected outcomes include reduction of medication administration errors, improved accuracy of diagnoses, and increased chart access, enabling healthcare teams to make more informed treatment decisions for patients. The system will foster enhanced coordination and improved continuity of care, as more accessible patient data and streamlined communication will lead to better team collaboration, both internally and with external care providers. Additionally, the EHR system will support data-driven decision making, and population health management by generating actionable data that can be leveraged to identify patterns, trends, and health or behavior issues affecting specific populations. Analyzing aggregate data can help develop targeted interventions which will improve overall treatment outcomes, including possible reductions in lengths of stay for patients. The projected outcomes can be directly linked to billing efficiencies, as the EHR system can streamline billing processes, allow for more accurate coding, and support documentation to justify the level of care provided, ultimately leading to improved financial performance for DSH.

The EHR project is not just a transformational initiative for clinical programs treating patients; the level of complexity, areas of responsibility, volume of IT systems, data, operating model, organization structure, and objectives that the DSH Technology Services Division (TSD) covers will increase in scale significantly. DSH is transitioning from paper based clinical care, to a fully electronic system to run the core of clinical functions when treating patients, which means a vastly increased support and reliance on TSD across all major facets of the organization from IT administration, project management, network, and server infrastructure, disaster recovery, security, application development and more. The EHR will demand resources, specific expertise, and the transformation of all existing IT support structures to roll out and maintain the system long-term.

DSH is approaching the implementation of the EHR system with an industry best practice in utilizing a digital first strategy. This strategy will allow DSH to demonstrate measurable positive results for:

- Meeting the increasing demand for healthcare services by using highly scalable digital products and services.

- Improving clinical outcomes by engaging, monitoring, and treating patients 24 hours a day, seven days a week, in their real world.

- Improving access and experience through digital capabilities that make it easy and convenient to access healthcare records.

D. Implementation Plan

DSH's ability to implement the EHR system is dependent upon hospital network capacity to support the EHR. DSH further estimates that planning, design, and deployment of the EHR system at DSH-Coalinga, the first site, will take about one year. Leveraging best practices in the standards and approach developed at DSH-Coalinga and applying lessons learned during deployment, DSH estimates that installation at the remaining four hospitals will take about two years to complete.

The following table shows the sequencing of the EHR implementation efforts along with estimated start and completion dates.

Objective	Start Date	Completion Date
CDT Completes edits and releases EHR RFO		August 2024
EHR Procurement complete — contract awarded		March 2026
EHR Vendor comes on board		April 2026
Site 1 - Coalinga EHR implementation	May 2026	March 2027
Site 2 – Metropolitan EHR implementation[1]	March 2027	June 2027
Site 3 – Atascadero EHR implementation[1]	June 2027	September 2027
Site 4 – Napa EHR implementation[1]	September 2027	December 2027
Site 5 – Patton EHR implementation[1]	December 2027	March 2028
System Stabilization	March 2028	July 2028

[1]A subsequent BCP will be submitted as system integrator payments won't be due until implementation at each location.

E. Supplemental Information (If Applicable)

Attachment A: Fiscal Detail Sheet

BCP Fiscal Detail Sheet

(Dollars in Thousands)

BCP Title: Continuum Electronic Health Record System

BR Name: 4440-052-BCP-2026-MR

Budget Request Summary

Personal Services

Personal Services	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
Salaries and Wages Earnings - Permanent	0	7,015	0	0	0	0
Total Salaries and Wages	**$0**	**$7,015**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$7,015**	**$0**	**$0**	**$0**	**$0**

Operating Expenses and Equipment

Operating Expenses and Equipment	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
5340 - Consulting and Professional Services - External	0	3,003	0	0	0	0
5342 - Departmental Services	0	6,300	0	0	0	0
5346 - Information Technology	0	15,970	0	0	0	0
539X - Other	0	1,565	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$26,838**	**$0**	**$0**	**$0**	**$0**

Total Budget Request

Total Budget Request	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
Total Budget Request	**$0**	**$33,853**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source

Fund Source	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
State Operations - 0001 - General Fund	0	33,853	0	0	0	0
Total State Operations Expenditures	**$0**	**$33,853**	**$0**	**$0**	**$0**	**$0**
Total Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$33,853**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding

Program Funding	FY26 Current Year	FY26 Budget Year	FY26 BY+1	FY26 BY+2	FY26 BY+3	FY26 BY+4
4400010 - Headquarters Administration	0	6,300	0	0	0	0
4400020 - Hospital Administration	0	27,553	0	0	0	0
Total All Programs	**$0**	**$33,853**	**$0**	**$0**	**$0**	**$0**