WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
January 23, 2020

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Call-in Number: 1-866-817-6550
Participant Passcode: 3190377

Mental Health Services
Oversight & Accountability Commission

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700, Sacramento, California 95814
Phone: (916) 445-8696 * Email: mhsoac@mhsoac.ca.gov * Website: www.mhsoac.ca.gov

Commission Meeting Notice

The Commission will be holding a regular scheduled meeting on Thursday, January 23, 2020, at 9:00 a.m. at the Mental Health Services Oversight and Accountability Commission Office located at 1325 J Street Suite, Darrell Steinberg Conference Room Suite 1720, Sacramento, California 95814.

Call-in Number: 866-817-6550; Code: 3190377 (listen only)

Our Commitment to Transparency

- The public is invited and welcome to attend all noticed meetings. A complete meeting agenda packet will be made available for inspection to all public members attending the meetings. Meeting notices and agendas of the Commission meetings required by the Bagley-Keene Open Meeting Act are accessible on the internet at www.mhsoac.ca.gov and are posted at least 10 days prior to the meeting.
- Further information regarding this scheduled meeting of the Commission may be obtained by calling (916) 445-8696 or email mhsoac@mhsoac.ca.gov

Public Participation

- The Commission welcomes participation at Commission Hearings. Members of the public may address the Commission on any agenda item of interest to the public.
- The public is requested but is not required to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. The Commission will also accept public comments via email, and US Mail.
- Participation during the "Public Comment" section will be limited to three (3) minutes per speaker, unless the Chair of the Commission decides a different time allotment is needed.

General Public Comment

- This is an opportunity for the members of the public to address the Commission on any matter that is not listed on the Agenda.
- Participation during the "General Public Comment" section will be limited to three (3) minutes per speaker, unless the Chair of the Commission decides a different time allotment is needed.

Americans with Disabilities Act

- Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in any Commission meeting or activities, may request assistance by calling (916) 445-8696 or email at mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

Commission Meeting Agenda
All matters listed as "Action" on this agenda, may be considered for action as listed. Any item not listed may not be considered at this meeting. Items on this agenda may be considered in any order at the discretion of the Chair.

9:00 AM **Convene and Welcome**
Chair Lynne Ashbeck will convene the Mental Health Services Oversight and Accountability Commission meeting and make announcements.

Transition Age Youth Representative

9:05 AM **Consumer/Family Voice**
Arden Tucker will open the Commission meeting with a story of recovery and resilience.

9:20 AM **Roll Call**
Roll call of Commissioners to verify the presence of a quorum.

9:25 AM **General Public Comment**
General Public Comment is reserved for items not listed on the agenda. No debate nor action by the Commission is permitted on such general public comments, as the law requires formal public notice prior to any deliberation or action on an agenda item. Public participation during the "General Public Comment" section will be limited to three (3) minutes per speaker, unless the Chair decides a different time allotment is needed.

9:40 AM **Action**
1: Consent Calendar
All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

1. Approval of the minutes from the November 21, 2019 meeting.
2. Approval of $2,158,704 in Innovation funding to support El Dorado County's extension of their Community HUBS Program approved by the Commission in August 2016.
   - Public Comment
   - Vote

9:50 AM **Action**

2: Youth Drop-In Centers Outline for Request for Applications

Presenter: Tom Orrock, Chief of Commission Grants, MHSOAC

The Commission will consider approval of an outline for the Youth Drop-In Centers Request for Applications.

- Public Comment
- Vote

10:45 AM **Information**

3: Overview of the Governor's 2020-21 Proposed Budget

Presenter: John Connolly, Deputy Secretary, Behavioral Health, Health and Human Services Agency

The Commission will be presented with an overview of the Health and Human Services part of the Governor's Proposed Budget for Fiscal Year 2020-21.

- Public Comment

11:15 AM **Action**

4: Overview of the Commission's 2020-21 Proposed Budget and the Commission's 2019-2020 expenditures

Presenter: Norma Pate, Deputy Director, MHSOAC

The Commission will be presented with an overview of the Commission's Proposed Budget for Fiscal Year 2020-21 and an update of the Commission's expenditures for 2019-20.

- Public Comment
- Vote

11:30 AM **Lunch Break**

12:15 PM **Information**

5: Executive Director Report Out

Presenter: Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

- Public Comment

12:30 PM **Action**

6: Amendment to the MHSOAC Rules of Procedure

Presenter: Filomena Yeroshek, Chief Counsel, MHSOAC

The Commission will consider adoption of the proposed amendments to the Commission's Rules of Procedures.

- Public Comment
- Vote

1:30 PM **Action**

7: Adopt MHSOAC Strategic Plan

Presenters: Toby Ewing, Executive Director, MHSOAC**,** Susan Brutschy, President, Applied Survey Research, Lisa Colvig, Vice President of Evaluation, Applied Survey Research

Applied Survey Research will present the final MHSOAC Strategic Plan and the Executive Director will discuss the implementation of the Strategic Plan.

- Public Comment
- Vote

2:30 PM **Action**

8: Legislative Priorities for 2020

Presenters: Assemblymember Sharon Quirk-Silva, Toby Ewing, Executive Director, MHSOAC

The Commission will consider legislative and budget priorities for the current legislative session including: SB 803 (Beall) Peer Certification; clarifying use of MHSA funding for services for individuals with potential co-occurring needs; expanding support for the Mental Health Student Services Act; and expanding the SMART/START initiative statewide.

- Public Comment
- Vote

3:30 PM **Adjournment**

AGENDA ITEM 1

Action

January 23, 2020 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of the following items placed on the Consent Calendar. The items on the consent calendar will be voted on without presentation or discussion unless a Commissioner requests an item to be removed from the Consent Calendar. Items removed from the Consent Calendar may be held over for consideration at a future meeting at the discretion of the Chair.

Approval of the November 21, 2019 MHSOAC Meeting Minutes:

Enclosure (1): November 21, 2020 Meeting Minutes

Approval of $2,158,704 in Innovation funds to support El Dorado County : extension of their Community HUBS Program approved by the Commission in August 2016.

This project was originally approved by the Commission on August 25, 2016 for up to $2,760,021 in innovation spending authority. The original project intended to promote interagency collaboration and partnered with County Public Health, the First 5 Commission and the County's Health and Human Services Agency by developing and placing five community hubs in local libraries within the County with the goal of increasing physical and mental health care access for families, pregnant women, and children.

The County is requesting an additional amount of $2,158.704 in innovation spending authority along with a nine-month time extension to address challenges the County experienced in relation to staffing, technology, and the analysis of data and reporting.

Enclosures (3): (1) Community HUBS Extension Staff Analysis; (2) Community HUBS Final Plan; (3) Letters of Support and Opposition for El Dorado Innovation Plan.

Lynne Ashbeck
Chair
Mara Madrigal-Weiss
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
November 21, 2019

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Reneeta Anthony
Ken Berrick
John Boyd, Psy.D.
Sheriff Bill Brown
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Lynne Ashbeck, Vice Chair
Mayra Alvarez
Senator Jim Beall
Keyondria Bunch, Ph.D.
Assemblymember Wendy Carrillo

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations

CONVENE AND WELCOME

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:08 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Tamplen reviewed the meeting protocols.

Announcements

Chair Tamplen provided the announcements:

- The next MHSOAC meeting is scheduled for January 23, 2020.
- The Youth Innovation Planning Committee is hosting the first Youth Innovation Idea Lab on Friday, December 6, at UC Santa Barbara from 11:00 a.m. to 3:00 p.m.
    - The Youth Innovation Idea Lab is a collaboration between the MHSOAC Youth Innovation Committee and the counties of Santa Barbara, Ventura, Kern, and San Luis Obispo.
    - There is room for more youth from each county to attend. Contact Shannon Tarter, MHSOAC Project Lead, with recommendations.
- An Immigrant and Refugee Forum was held in San Diego last week. Staff visited a center run by Jewish Family Services.
    - Chair Tamplen commended Jewish Family Services, a nonprofit organization serving immigrants and refugees for over 100 years, for their care, compassion, and professionalism in how they serve families and thanked Commissioners Alvarez and Madrigal-Weiss and staff for bringing this event together.
    - Chair Tamplen recommended inviting members of the panel who spoke at the forum to present at a future Commission meeting on ways of addressing current issues.

Chair Tamplen invited Executive Director Ewing to introduce a new staff member. Executive Director Ewing introduced Andrea Anderson, the new MHSOAC Communications chief.

Youth Participation

Chair Tamplen stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Jorge Campos, from Stepping Stones Transition Age Youth (TAY) Resource and Support Center and Pathways to Success Program, introduced himself when he arrived later in the meeting.

Consumer/Family Voice

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited Mary Hogden to share her story of recovery and resilience.

Mary Hogden, Manager, Alameda County Pool of Consumer Champions, shared her story of growing up in a large dysfunctional family with a mother with a mental health diagnosis and a grandmother who was in a mental institution her entire life. She remembers her mother having conversations with an invisible friend and feeling that she

was not loved and that she was not getting enough attention. Her family suffered domestic violence, abuse, and neglect.

Ms. Hogden stated she began experimenting with drugs and alcohol and living that lifestyle, so she did not have to pay attention to what was going on in her own home. She felt shame for her family; the last thing she wanted to do was to go home much less invite someone over. She stated she got caught up in the criminal justice system as a juvenile and was incarcerated from her late teens through her twenties. She stated, when she was not incarcerated, she had a needle in her arm.

Ms. Hogden married a person who mirrored the same lifestyle as Ms. Hogden's family. She stated her way of dealing with that was to use more drugs and alcohol.

Ms. Hogden stated she was given the opportunity to go to a drug and alcohol rehabilitation program called the Delancey Street Foundation. She stated Delancey Street accepted her, even though she had been incarcerated four times, was a functional illiterate with a 9th grade education, had no job skills and no interpersonal skills, and had lost sight of any type of values.

Ms. Hogden stated, when she arrived at Delancey Street in South Carolina, she had so much pain and did not trust anyone. She could not trust her own family, let alone anyone trying to instruct her on how she should live. She stated she learned something important about herself two years into Delancey Street – she was good at giving people support around their issues. She stated she found herself encouraging others to change their ways so they would not be locked up for the rest of their lives or end up dead on the streets.

Ms. Hogden stated she got her life together, went back to school, and got her psychology degree during her five and a half years at Delancey Street. When she left Delancey Street, she started a program called First Incorporated in North Carolina. After twelve years, it had grown to a huge organization. She was loving her life and loving her job. She stated giving back to others and helping someone else is the kind of high that does not wear off. She became passionate about changing the system, but twelve years in, she had a psychotic break where she began seeing and hearing things and became paranoid.

Ms. Hogden stated she resigned from First Incorporated and returned to the area where she grew up, even though one of the things taught in recovery is never to go back to the old playground or playmates. She relapsed back into drugs after returning to her old neighborhood, became homeless, and was so "weird" that even the drug addicts did not want to be around her. She stated she knew, if she did not get away from the place she grew up, she would not survive. She stated she went to California.

Ms. Hogden stated this was an enormous journey. She stated she had many 5150s, suicide attempts, and interactions with law enforcement. She stated law enforcement was not all bad, although they did not understand that she could not process the information that was being given to her. In 2005, she ended up homeless and being badly beaten on the street in Berkeley. She stated law enforcement took her to the hospital and helped to get her into a safe house, where she was able to get mental health treatment.

Ms. Hogden stated the mental health treatment included a psychiatrist and she was on medication for many years, although she is medication-free today. She was introduced to the Pool of Consumer Champions (POCC) in Alameda County. She stated she found her wellness by engaging and connecting with peers. She stated she liked the idea of the POCC transforming the mental health system. She stated mental health used to be separated from substance use, but she advocated that there is no separation. There are many individuals who self-medicate through substances. She stated she believes strongly in justice reform and that more needs to be done as a community.

Ms. Hogden stated her appreciation for the support of the MHSA and the MHSOAC for the POCC. She went from volunteer to Manager of the POCC. She stated work is a wellness tool. She stated she loves to work and to help someone along the road. Someone helped her and saw something in her when she could see nothing in herself. It is everyone's responsibility to reach down and help someone up to the top. Everyone needs peer support.

Comments and Discussion

Commissioner Mitchell stated the Commission has heard many stories but Ms. Hogden's tops them all. She stated Ms. Hogden functioned so well for those twelve years and then something happened. She stated this shows that the mind and mental health is unpredictable. She thanked Ms. Hogden for sharing her journey of recovery with the Commission.

Commissioner Wooton thanked Ms. Hogden for managing the POCC and being a great leader so Chair Tamplen could be a part of the Commission.

Commissioner Anthony thanked Ms. Hogden for sharing her story. She stated Ms. Hogden's family history is very similar to her own. She stated her belief that individuals are the sum of their experiences for a reason. She stated Ms. Hogden is a blessing to the Commission and to the POCC. She encouraged Ms. Hogden to continue sharing her story because it gives hope to others.

Commissioner Brown stated Ms. Hogden is an inspiration and her story is incredible. He stated Ms. Hogden is a shining example of what can happen through the recovery process and that redemption is a beautiful thing. The fact that Ms. Hogden had a second fall demonstrates that recovery is a process and not an event. He noted that programs are often considered failures because not all individuals stayed on track, but the reality is the learnings and experiences of programs like Delancey Street, even if there is a fall, are a foundation to go back to when the next opportunity arises to make the decision for improvement. Ms. Hogden agreed.

Commissioner Brown stated it is important for providers, individuals involved in policy, and the general public to understand that recovery is complicated sometimes. It is not absolute; it is different for different people. He encouraged Ms. Hogden to continue telling her story.

Chair Tamplen stated one of the most important things highlighted during Ms. Hogden's testimony was that having a meaningful role, whether volunteering or finding a job and connecting with people who have experienced similar things and do not judge but are

together on the journey of recovery is powerful. She stated in whatever ways spaces can be created for peer consumers to have meaningful roles gives them opportunities to reach out to one another.

Chair Tamplen thanked Ms. Hogden for her leadership around Crisis Intervention Team (CIT) trainings and talking to law enforcement throughout the state.

Chair Tamplen stated one thing not discussed enough is the needs of older adults. She stated Ms. Hogden is an advocate for hearing the voice of older adults and not forgetting that elders also experience these traumas and hardships. She stated the need to listen to all voices and to move forward in finding ways to solve problems in the state.

ACTION

1: <u>Approve September 26, 2019, MHSOAC Meeting Minutes</u>

Chair Tamplen asked for any discussion on the minutes of September 26, 2019.

Public Comment

Poshi Walker, LGBTQ Program Director, Cal Voices, a continuation of Mental Health America of Northern California (NorCal MHA), Co-Director, #Out4MentalHealth, referred to the second paragraph of the public comment section on page 9 and asked to change the word “binary” to “nonbinary” so the sentence would read “it was learned that the QTPOC community has greater disparities than White LGBTQ individuals and that transgender and nonbinary individuals have huge disparities.”

Poshi Walker referred to the first paragraph of the public comment section on page 21 and asked to change “and/or” to “and” so the sentence would read “the speaker suggested making a place on the agenda for the CLCC and the CFLC to educate the Commission about a portion of the population.”

Commissioners Anthony and Berrick agreed to include Poshi Walker’s edits.

Action: Commissioner Anthony made a motion, seconded by Commissioner Berrick, that:

The Commission approves the September 26, 2019, Meeting Minutes as revised on pages 9 and 21 to reflect corrections to Poshi Walker’s public comments.

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Anthony, Berrick, Boyd, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Tamplen.

The following Commissioners abstained: Commissioners Brown and Wooton.

ACTION

2: <u>Suicide Prevention Strategic Plan</u>

Presenter:

- Ashley Mills, Senior Researcher, MHSOAC

Chair Tamplen stated the Commission will consider adopting "Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025." She invited Commissioner Wooton, Chair of the Suicide Prevention Subcommittee, to share about the project.

Commissioner Wooton thanked the Subcommittee members, staff, and everyone around the state who helped create the Suicide Prevention Strategic Plan. She highlighted positive things learned in the focus groups held throughout the state. She read the dedication on page 4 of "Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025," which was included in the meeting packet.

Chair Tamplen invited Commissioner Madrigal-Weiss, a member of the Suicide Prevention Subcommittee, to share about the project.

Commissioner Madrigal-Weiss thanked fellow Commissioners and staff members, especially Ashley Mills. She stated her appreciation that prevention for youth is highlighted in the Suicide Prevention Strategic Plan. It is important to involve all systems in suicide prevention.

Chair Tamplen stated it has been an honor to work with fellow Commissioners, staff, and the community to bring this incredible work together. She asked staff to present this agenda item.

Ashley Mills, Senior Researcher, Suicide Prevention Project Lead, MHSOAC, provided an overview, with a slide presentation, of the background, strategic aims and goals, project activities, and state workplan for "Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025."

Commissioner Questions and Discussion

Commissioner Boyd asked if new contributions to the field were discovered during the research phase.

Ms. Mills stated an important part of the Suicide Prevention Strategic Plan was to acknowledge the inherent barriers to preventing suicide, most notably of which is stigma, but also disparities, access to health care, and individuals living in isolated communities. She stated part of that stigma is treating suicide prevention as if it is "other," when it is part of a larger, broader public health prevention strategy. Bringing that suicide prevention framing into other disciplines will be a challenge moving forward. She stated the Suicide Prevention Strategic Plan is unique in many ways, but it is unique in recognizing that there are significant barriers that will take a concerted effort to overcome.

Ms. Mills stated, beyond that, it also highlights innovations. There are many innovations around technology and supporting health care providers to use technology-based

applications to do screenings and decision trees to determine the care pathway for each individual. Developing infrastructure for the care pathways and having technology support those pathways is a huge opportunity. She stated leveraging technological advancements aligns with best practices and will also help alleviate some of the burden on workforce. She stated many innovative strategies are proposed within the Suicide Prevention Strategic Plan.

Commissioner Boyd stated many siloes still exist throughout the United States and other countries. He stated the hope that the Suicide Prevention Strategic Plan includes forward thinking around how to take the highlight of relatively new innovations or other unique contributions to the field and figure out how to proactively spread them not only throughout the state but also throughout the country.

Commissioner Boyd asked, although he has great confidence in Governor Newsom's commitment to mental health, beyond that and beyond the reference to other agencies, how will this Suicide Prevention Strategic Plan become a priority within California to make a meaningful difference so it will not become just another report or topic because, although suicide is a public health crisis, it is not treated as such. He asked for updates throughout this next year on ways the Commission can help make the Suicide Prevention Strategic Plan a priority in California.

Executive Director Ewing stated the importance of understanding the context through which the Suicide Prevention Strategic Plan came to the Commission, where the Commission is in that context, and what that looks like moving forward. Last year, the Legislature provided ongoing funding for a suicide hotline statewide. Assembly Bill (AB) 114 mandated the Commission to draft the official Suicide Prevention Strategic Plan for the state of California.

Executive Director Ewing stated conversations are ongoing with the Legislature on how to actively implement the Suicide Prevention Strategic Plan statewide. Staff has highlighted recommendations in the report at legislative meetings that lend themselves for implementation in the upcoming Governor's January budget proposal. He stated the conversations that the Legislature had in terms of funding has strengthened the idea that suicide is a state responsibility as opposed to a county responsibility.

Executive Director Ewing stated there are things in the Suicide Prevention Strategic Plan that can happen right away through the state and things that can happen through partnerships with the private sector and civic organizations. He stated the auditor recently began an audit of suicide prevention strategies in schools in response to legislation that was passed a couple of years ago. That signals that policy holders are not satisfied with simply writing a report but that they want to know what will be done about it.

Executive Director Ewing stated the first step is to ensure the Suicide Prevention Strategic Plan is correct and is approved by the Commission to direct staff to work with the Governor, Legislature, and other partners to make this happen. He agreed with regularly updating the Commission on what has been done to make this a reality.

Commissioner Boyd suggested also hearing an update on the "Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness" criminal justice

report that Commissioner Brown did and getting a status update on what material things have shifted or changed and if there are opportunities to continue to leverage this body of work.

Commissioner Berrick thanked fellow Commissioners and staff for this extraordinary piece of work. He agreed that there is a crisis, especially with children and youth. He suggested that, as the Commission prioritizes action on this, there be an item on the agenda about a major initiative that creates an opportunity around suicide strategies in schools.

Commissioner Danovitch stated the Suicide Prevention Strategic Plan is an exceptional work, the report is outstanding in respect to its content, clarity, and presentation of information, and it is a model for the level of effectiveness the Commission wants to have with its communications.

Commissioner Danovitch noted that there is one area that is not addressed in the report that bears mentioning – the overlap between suicides and overdose. He suggested that this be highlighted in the report. Although the report operates at a high level, it does not get into conditions with specific issues. The reasons that overdoses represent a strategy that is worth incorporating are the impact, the opportunity in terms of leveraging and blending efforts around overdose prevention, and integration. The failure to address overdose leaves a huge opportunity on the table and does not serve the individuals the Commission is trying to serve. He asked for guidance on how to incorporate overdose in the report. He suggested the Commission's adaption of the report include instructions to add a strategy to incorporate a way to address that component.

Commissioner Gordon stated this is a great work product. He agreed with Commissioner Berrick about getting to the schools and youth, both K-12 and the colleges. He stated it is interesting to see that one of the three myths is that talking about suicide promotes it. He stated disseminating the results of this study and putting out calls to action to various players in the system could be a huge advance to getting this on the agenda of various conferences, and that is something the Commission can do immediately that will be very fruitful.

Commissioner Gordon stated he also agreed with Commissioner Danovitch about the connection to overdose.

Commissioner Gordon stated he was troubled with the notion that, when thinking about innovation, it is often thought about around anything but bureaucracy. He cautioned that the next step of creating an office of suicide prevention within the Department of Public Health may give people an excuse to consider it taken care of since there was a bill and an office was put in place. He suggested saying something different because offices and agencies are territorial by nature. He suggested adding to the motion that there be the creation of a high-level multiagency office where there would be a forced collaboration among all of the major players, because what is really needed is for the key agencies to collaborate and coordinate as a normal part of their workload.

Commissioner Mitchell asked if it will be a requirement that counties implement the Suicide Prevention Strategic Plan.

Ms. Mills stated the Suicide Prevention Strategic Plan is only a plan. Anything beyond that would be held in discussions with members of the Legislature and the Governor's Office. That is a next-step conversation. There is a significant amount of activity happening at the local level around suicide prevention. She stated counties currently are acting on coalitions and plans. This document can help support that. Beyond that in terms of a mandate around suicide prevention would be a next step that could be explored.

Commissioner Mitchell asked if there was a consideration for an identification of specific groups in the Suicide Prevention Strategic Plan, such as youths, African Americans, or LGBTQ. She asked if the prevalence of suicide has been extrapolated for those communities, if there will be a place to specifically target prevention strategies for those most at-risk groups, and if that has been identified to be implemented at the county level in the Suicide Prevention Strategic Plan.

Ms. Mills stated one of the key foundational frameworks for the Suicide Prevention Strategic Plan and others is the public health approach, which is using data to describe the problem of suicide behavior in communities, identifying risks and protective factors, building strategies around that data, and evaluating it. She stated, if something works, it can be brought to scale and, if something does not work, it can be examined and used for change. It is based on the foundation of using data and information.

Ms. Mills stated one of the key areas needed to be strengthened is the data systems to better understand suicidal behavior. Each community has different characteristics. The Suicide Prevention Strategic Plan addresses common characteristics among all communities by using data and information provided by individuals with lived experience to help guide decision making around developing plans and strategies. She stated this is a key foundational aspect of the Suicide Prevention Strategic Plan and many state and national plans, but it will also take a significant investment in strengthening the data to ensure that local communities have data to begin describing what suicide behavior looks like in their community.

Commissioner Anthony thanked everyone who participated in the creation of the Suicide Prevention Strategic Plan. She referred to the last sentences in the dedication on page 4 of the Suicide Prevention Strategic Plan, which state, "The Commission affirms the urgency of putting in place sound strategies to prevent further loss of life. Lives can be saved. There is hope." She shared her experience with suicide within her family. She stated every life is important, no matter the age, the ethnicity, or the background.

Commissioner Anthony stated this is a wonderful report as presented. She stated everyone has priorities, but it is up to the communities with an overall broad plan such as was presented. She spoke in support of the Suicide Prevention Strategic Plan and the recommendations as written.

Chair Tamplen echoed the gratitude of the leadership, how the plan was rolled out, and the inclusiveness in the creation of the Suicide Prevention Strategic Plan. She agreed with Commissioner Danovitch about elevating the connection around overdoses and suicide. She suggested translating the report into the threshold languages in California.

Commissioner Danovitch asked about the most useful way to advance his suggestion to highlight the connection between suicide and overdose.

Ms. Mills stated there are many options. Within the Suicide Prevention Strategic Plan, under each Strategic Aim and Goal, the number one state objective is to convene a task force. The Office of Suicide Prevention is framed out as a convener to bring together public and private partners. The State Work Plan outlines that through a series of task forces. Those task forces will take deeper dives into lethal means restriction, connectiveness, screening and detection, and providing services after a death by suicide.

Ms. Mills stated there are opportunities for the Commission to advance the role of a state convener to bring task forces together made up of a broad range of subject matter experts to deliberate and unpack much of the opportunities. She stated the Commission could also support staff to work with other partners to increase options for data and understanding how to strengthen the data infrastructure already in place. Part of the challenge is describing suicidal behavior. This can be done through data but the data is currently limited. The Commission could direct staff to work with others to advance data monitoring and collection and the use of the current data. Staff could also do a project to look at systems integration to determine the latest advancements around integrating systems in health care settings.

Commissioner Brown responded to Commissioner Danovitch's comment about the overdose situation. He stated, being a coroner as well as a sheriff, he is often faced with overdose deaths that are difficult to determine whether they were suicides or accidental. He agreed that there should be mention of that in the report, although it will be a very challenging area. He stated one possible thing that could be done would be to conduct psychological autopsies but this would require a significant additional resource allocation. He stated the numbers are probably underreported – many deaths that are ruled as accidental deaths are, in all likelihood, suicides.

Commissioner Brown commended staff on having a one-sheet resource page. He recommended including the suggestion on the page to take a cell phone photo of it to have as a resource at all times. He suggested reworking the page to talk about if someone is showing warning signs or communicating the desire and to include a few of the possible warning signs.

Commissioner Brown commended Commissioner Wooton, fellow Commissioners who were on the Subcommittee, and, in particular, Ms. Mills for their tremendous work. He stated Ms. Mills is a gifted researcher and has done a magnificent job.

Commissioner Berrick suggested including a term on the title page that could easily be searched for so that, when individuals search for a suicide-related term, the Internet points to the Suicide Prevention Strategic Plan, where they can get help.

Commissioner Danovitch stated, irrespective of the complexities of the data, there are opportunities for intervention. This is a great opportunity to give visibility to this issue and to inform planning. He stated the importance of elevating the topic of suicide and overdose within the report so it does not ultimately get expressed through the tactics

and strategies but is seen as an integral issue and informs thinking about it as an integral component of other mental health strategies.

Commissioner Gordon stated the messaging in the report is strong except for the idea that suicide prevention is everyone's problem. It is not just a health problem. The Commission has the platform to wake everyone up to that fact instead of continuing to believe that someone else will take care of it. Whether it is changing the messaging or the report, it is a very important statement to make.

Executive Director Ewing stated staff has had conversations with the Legislature around presumptive eligibility for MHSA funds when it is unclear whether the primary cause is an addiction issue or a mental health issue. The idea is to empower counties to have greater flexibility in using MHSA funds to respond to these needs and not to raise it as a negative issue in an audit, if it turned out it was primarily an addiction issue, because of the high rate of co-occurrence. Using the Suicide Prevention Strategic Plan as an opportunity to highlight that is consistent with recognition and the reality that it has not gotten traction. He suggested approving the Suicide Prevention Strategic Plan with a note that staff would work with Commissioner Danovitch to incorporate language that would highlight the intersection with addiction, and with Commissioner Gordon to elevate the language.

Commissioner Mitchell agreed with Commissioner Danovitch that there is a huge intersectionality between suicide and overdose. It is important to include that because it affects every community.

Commissioner Wooton stated the Commission requires additional resources in order to be a lead around the Suicide Prevention Strategic Plan. She suggested including in the motion a request for funding for resources, specifically for a lead for the Suicide Prevention Strategic Plan within the MHSOAC to begin the next steps of implementing the Plan.

Commissioner Wooton moved to adopt the "Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025," including direction to staff to seek funding and to work with Commissioners Danovitch and Gordon to address their concerns. Commissioner Danovitch seconded.

Public Comment

Maria Fuentes, Retired, Santa Clara County Public Health, suggested paying closer attention to cultural competency and emphasizing the needs of specific ethnic communities throughout the state. The speaker agreed that working at the county level and looking at the needs of specific groups is essential.

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, spoke in support of the proposed Suicide Prevention Strategic Plan. The speaker suggested using the model of the Office of Aids, which is housed within the Center for Infectious Disease, as opposed to creating a new Office of Suicide Prevention. The speaker suggested that the Office of Suicide Prevention be housed within the Center for Healthy Communities with the California Department of Public Health.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), echoed the comments of Maria Fuentes. The speaker spoke in support of the proposed Suicide Prevention Strategic Plan. The speaker also stated building on the data does not guarantee that it translates into culturally competent services or approaches. The speaker suggested including language that the problems and solutions need to be defined culturally competently. It is also important that the task force includes individuals from these special populations.

Jean Harris, consumer and advocate, suggested addressing the suicide prevention and mental health of children from elementary school and up. The speaker stated the need for peer mentors and storytellers to share the lived experience and to address nutritional psychology, which can cause mental health issues. The speaker suggested using a term other than “committing” suicide.

Poshi Walker echoed the comments of Maria Fuentes, Mandy Taylor, and Jean Harris. #Out4MentalHealth will be releasing more specific data regarding LGBTQ suicide from their community survey. The speaker stated the hope that, as the Suicide Prevention Strategic Plan is implemented, LGBTQ and especially queer and trans people of color are continued to be included.

Poshi Walker stated LGBTQ youth appear to be at highest risk and 25- to 54-year-olds were at higher risk of lethality in terms of needing medical intervention after an attempt in the past year. The speaker stated, without sexual orientation and gender identity data on violent death, which includes suicide, the needs and outcomes regarding LGBTQ suicide will not be known in the future.

Pharaoh Mitchell, Community Action League, stated there is no such thing as accidental death and overdose. The speaker stated they are suicides because each drug addict takes the drugs hoping that they will die one day. There is no difference between an overdose and suicide because each person who has an addiction is taking these drugs to pass away sooner rather than later. African Americans begin using drugs at a young age because they do not want to face the same lives that their parents lived. The speaker stated it is important that the grassroots organizations and the individuals who are touched by this, be a part of this. The speaker stated concern as an African American about what the Suicide Prevention Strategic Plan will look like on the ground because there have been so many programs and promises about change in the community and nothing ever changes.

Dr. Lisa Pion-Berlin, President and CEO, Parents Anonymous, Inc., suggested adding the California Parent Helpline to the list of resources. Parents often do not want to go to the emergency room because the first thing that will happen is that it will be reported to Child Welfare and their child will be removed from their home, but many parents call the helpline and attend evidence-based parents’ anonymous groups. This is missing from the report.

Action: Commissioner Wooton made a motion, seconded by Commissioner Danovitch, that:

The MHSOAC adopts Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025, including direction to staff to seek funding and to work with Commissioners Danovitch and Gordon to address their concerns.

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Boyd, Brown, Danovitch, Gordon, Madrigal-Weiss, Mitchell, and Wooton, and Chair Tamplen.

ACTION

3: Mental Health Student Services Act Request for Proposals Outline

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants, MHSOAC

Commissioners Berrick, Gordon, and Madrigal-Weiss recused themselves from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Chair Tamplen stated the Commission will consider approval of the outline for the Mental Health Student Services Act Request for Proposal (RFP), for a competitive bid process to distribute $75 million to support school and county partnerships to implement the programs described in the Mental Health Student Services Act (MHSSA). She asked staff to present this agenda item.

Tom Orrock, Chief of Stakeholder Engagement and Grants, MHSOAC, provided an overview, with a slide presentation, of the MHSSA objectives, role of the Commission, information on the Commission's listening sessions, outline for the grant apportionment and costs, and the program plan of the RFP Outline.

Commissioner Questions

Jorge Campos spoke in support of the peer support component.

Public Comment

Gina Plate, California Charter Schools Association and Advisory Commission on Special Education, asked that the Commission consider, when evaluating the applications, the unique options that are available to charter schools. The speaker suggested that the Commission support the structure proposed earlier specific to new schools or new partnerships versus existing partnerships and consider those that are demonstrating innovative thinking. The speaker provided their written comments to staff.

Commissioner Discussion

Commissioner Wooton agreed with Jorge Campos that peer support should be brought to the forefront. She suggested including the hiring of youth to help with this initiative within the RFP.

Mr. Orrock stated peer support is called out in the Mental Health Student Services Act. It can be included in the RFP so proposers will consider different ways to use peer support.

Commissioner Anthony stated it is important for this unique Commission to be results-based. She suggested that the RFP include the requirement for outcomes that are results-based.

Mr. Orrock stated outcomes are part of the responsibility for the Commission to create metrics for measurable outcomes such as linkage to services, length of time spent in services, parent satisfaction, suicide rates, suspensions, expulsions, and other measures that come out after the winning proposals are selected.

Commissioner Brown referred to the presentation slide with the list of populations for the counties and stated the population for Santa Barbara County is incorrect. It should be approximately 445,000.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Mitchell, that:

- *The Commission approves the proposed outline of the* Mental Health Student Services Act *Request for Proposal.*
- *The Commission authorizes the Executive Director to initiate a competitive bid process.*

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Anthony, Boyd, Brown, Danovitch, Mitchell, and Wooton, and Chair Tamplen.

Commissioners Berrick, Gordon, and Madrigal-Weiss rejoined the Commissioners at the dais.

GENERAL PUBLIC COMMENT

Stacie Hiramoto thanked the Commission for the Immigrant and Refugee Forum in San Diego. The speaker stated the hope that there will be actions as a result of what was presented at the forum and that the information presented at the forum will be presented to the Commission in more ways than a written report. In this way, the valuable information can be presented for future initiatives at the Commission. The speaker stated information is a first step but, just as with presentations on diversity and cultural competence, what really matters is actions afterwards, especially regarding policy change and funding.

Susan Gallagher, Executive Director, Cal Voices, a continuation of NorCal MHA, stated Cal Voices put in a public records request for information for the Technology Suite Collaborative Innovation Project (Tech Suites). The speaker shared their initial findings in those records. The speaker stated it looks like $20 million has been spent so far. Cal Voices’ largest concerns are that privacy issues and informed consent have yet to

be addressed and there is no product availability. Most of the funding has gone into research and development at this point.

Susan Gallagher stated Modoc County pulled out of Tech Suites and 7 Cups is no longer part of the project. This raises the following questions: What happens when a vendor is removed? What happens to the data they have collected? Where does the funding that was put into product development go?

Susan Gallagher stated one of the things that came out indicated that the primary focus of the California Mental Health Services Authority (CalMHSA) and counties during the second quarter was to build capacity to establish a minimally-viable product for the two Tech Suite applications. The speaker stated, as of July, there was no minimally-viable product available. The speaker stated Cal Voices has deep concerns about this and wanted to bring it to the Commission's attention since the Commission approved those projects.

Susan Gallagher suggested pausing the Tech Suites project until there is more clarity about who the vendors are, what will happen with this information, whether there is informed consent, whether the privacy concerns have been addressed, and whether the data will be sold to a third party. The speaker stated Cal Voices' questions have yet to be answered.

Mandy Taylor stated the California LGBTQ Health and Human Services Network is part of the #Out4MentalHealth project, which is a part of Cal Voices. The California LGBTQ Health and Human Services Network has been funded through the Commission since August of 2017. A report is submitted each quarter that details the advocacy done across the state, outreach through events, newsletters, social media, training on a range of issues throughout the state, and details regarding community voices for the annual State of the Community Report. Also included is a two-page summary of the work done in that quarter. Each month, a list of events is submitted.

Mandy Taylor stated the California LGBTQ Health and Human Services Network has asked multiple times to be allowed to present this information to the Commission. The speaker asked for the opportunity to present a special population briefing on the work that is being done throughout the state. The speaker requested scheduling 15 to 30 minutes at each meeting for briefings, asking Commission staff to forward the quarterly summaries to Commissioners, and posting the annual reports on the MHSOAC website.

Poshi Walker echoed Susan Gallagher's comments. The speaker stated #Out4MentalHealth has many concerns about the Tech Suites. The speaker stated #Out4MentalHealth has sample policies and recommendations that they would love to make available to the Commission.

Poshi Walker stated "nothing about us without us" is an important value of the MHSA and, as an advocate, they are grateful for the ability to make public comment prior to a Commission vote. The speaker stated they have mentioned before that there is at least an appearance that public comment is often not considered as part of the decision-making process. The speaker respectfully suggested, after public comments are heard, to not immediately go to the vote but instead add a step of asking Commissioners if

there is any additional discussion now that they have heard from the public. This additional step would add value to the process and strengthen the commitment and responsibility of the MHSOAC to include the stakeholder involvement and voice at all levels of decision-making.

LUNCH BREAK

ACTION

4: <u>Stakeholder Request for Proposals Outline</u>

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants, MHSOAC

Chair Tamplen stated the Commission will consider approval of an outline and authorization for the release of six RFPs to support advocacy, training, and outreach efforts on behalf of Clients and Consumers, Diverse Racial and Ethnic Communities, Families of Clients and Consumers, LGBTQ Communities, Parents and Caregivers of Children and Youth, and Veteran Communities. She asked staff to present this agenda item.

Mr. Orrock provided an overview, with a slide presentation, of the background, community engagement process, contract structure and funding, and next steps of the Stakeholder RFPs.

Commissioner Questions

Commissioner Mitchell moved the motion as presented. Commissioner Brown seconded.

Public Comment

Melissa Hannah, Grant Coordinator, United Parents and Parents and Caregivers for Wellness, echoed Mandy Taylor's comments about sharing with the Commission the wonderful and beneficial work being done. The speaker asked if there will be a bidder's conference following the release of the RFP.

Mr. Orrock stated a bidder's conference is not written into this RFP but there is a question and answer period where proposers can send in questions. The answers to all questions received will be released at the same time. This is similar to a bidder's conference in that everyone gets the same information at the same time.

Dr. Pion-Berlin stated the two-year requirement to be a statewide entity seems to be a very small amount of time to take on this role of state advocacy in a state with a population of 42 million individuals. The speaker suggested requiring at least five years of experience doing statewide advocacy.

Dr. Pion-Berlin stated each stakeholder group will be given the same amount of funding but they do not represent the same number of individuals in the state. This needs to be taken into consideration.

Dr. Pion-Berlin stated the need to be creative with technology because each stakeholder group has restrictions with time and resources to travel to the Capital for advocacy.

Mandy Taylor stated a letter from the California LGBTQ Health and Human Services Network was sent to the Commission. The speaker pointed out that the proposed RFP relies heavily on local events. Long-term sustainable mental health equity is generally not accomplished through one-time events. The speaker stated task forces, trainings, and town hall events are held throughout the year but these are not where mental health equity is happening. These are ways of informing the community about what is happening, supporting the community, and getting connected with ongoing efforts, but these do not make change.

Mandy Taylor stated, if events are included in the RFP, each community needs to decide what that looks like for their own community. The speaker stated the need for the requirements to be holistic, not prescriptive.

Mandy Taylor stated, for local organization responsibilities, it is not culturally appropriate to expect an under-resourced community that has been historically excluded from or oppressed by systems to have behavioral health relationships in place. Time must be spent to help them to make those connections.

Melen Vue, Vice President of Programs and Services, National Alliance on Mental Illness (NAMI) California, respectfully requested that the Commission reconsider the due dates of the proposals. The speaker asked that all proposals be submitted on the same day and that the due dates be extended to February with the review and approval completed by March. The speaker also asked that the contract be executed and implemented as outlined in the RFP with adherence to the proposals as submitted.

Stacie Hiramoto thanked the Commission for keeping the focus at the state level. Advocacy needs to be at the state level and not just at the local level. Having individuals at the local level participate in this is difficult and will take effort at the state level. The speaker stated the need for ample funds for state-level activities to coordinate this.

Stacie Hiramoto suggested including a requirement for a representative for the entity representing each community to come to Commission meetings.

Stacie Hiramoto stated local communities have different levels of capacity. Each community should not be awarded the same amount of funding. The speaker stated what is good for one community may not be the same thing that is required for another county. The speaker stated the Commission should not micro-manage the funds.

Poshi Walker stated this timeline was difficult and created problems during past RFPs. It was difficult to reach individuals in December and the holidays lengthened the process. The speaker strongly suggested that the Commission wait to release the RFPs until January.

Poshi Walker stated the LGBTQ community was not involved in the listening sessions in the first round of RFPs and were not very involved in the second round. The speaker agreed with the need for the requirements to be holistic, not prescriptive.

Pharaoh Mitchell provided the background of post-traumatic slave syndrome. The speaker stated millions of dollars are being put into communities, but it is not reaching down to the grassroots organizations that are doing the footwork to change communities. The African American community is not being represented even though they are the largest numbers in all the systems. The speaker asked the Commission to begin working with the grassroots organizations to help solve problems in the community.

Amparo Ostojic, ACCESS Ambassador, ACCESS California, Cal Voices, spoke in support of the proposed stakeholder RFPs. The speaker shared what it is like to be an ACCESS Ambassador.

Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), Peers Envisioning and Engaging in Recovery (PEERS), spoke in support of the RFP outline. The speaker asked for clarification of what is meant by the word “events” because the definition may be too narrow. One event per year per county for a community of consumers may not be enough or may not be the best use of funds for that community. The speaker stated those consumers may instead need more peer respites in the community or advocacy and support to organize self-directed care throughout the year.

Dawniell Zavala, Associate Director, Cal Voices, and Program Director, ACCESS California, stated working in local communities and doing statewide work is possible. The speaker agreed with Dr. Pion-Berlin about the funding levels. Funding levels should be based on the overall size of the populations being served. The speaker agreed with Mandy Taylor and Poshi Walker about keeping the deliverables open and not too prescriptive to let experts come up with ways to accomplish the deliverables for matters that make sense for the overall program.

Dawniell Zavala stated the outline overview indicates that the funding for these programs comes from the designation under Welfare and Institution Code Section 5892(d). The speaker stated the need for the activities in the RFPs to reflect the purposes and goals in that section. This should be highlighted in the RFPs.

Bianca Gallegos, ACCESS Ambassador, spoke in support of the funding for Cal Voices.

Commissioner Discussion

Commissioner Anthony stated she has over 30 years of experience in grant development. She emphasized that building and developing relationships in a formal manner is the way to share information and expand services at the local and state levels. The public comment process is an opportunity to build upon what has been experienced. The proposals can be written based upon the criteria of the RFP. It can be whatever the applicant defines it to be.

Mr. Orrock stated the Commission is asking proposers to consider the most creative way, through a community engagement plan that they develop, to meet the objectives to provide state and local advocacy. It is less prescriptive than past stakeholder RFPs and allows proposers to put together the best way they feel that they can accomplish those goals.

Commissioner Anthony stated it is an opportunity for everyone to work together and to bring forth proposals to address representation and outreach efforts.

Chair Tamplen stated there was a question during public comment about clarifying the meaning of the word “events.”

Mr. Orrock stated proposers are intended to provide a creative plan for holding events. The events are not necessarily one-day meetings. There is one-time funding for events, but there are also funds for ongoing advocacy efforts beyond events. The hope is that the state-level organization would work closely with the local organization that they are working with, if they choose to do it that way, and that that would be ongoing through the 39-month period.

Commissioner Mitchell stated 15 events over three years seems reasonable and would not consider it micro-managing. She asked the members of the public for further comment to clarify the issue.

Commissioner Gordon agreed. He stated the way it is currently written could be perceived as a conventional event being the only thing that would count as an event. He stated the need to temper the language to be more like what Mr. Orrock explained.

Public Comment

Mandy Taylor stated there are two things that would be helpful to clarify. One of the reasons for the concern about events is coming up is because of the way the points were scored in the TAY RFP. Out of approximately 9,000 points, 6,500 of those points are solely based on events. Advocates know events are only a product of what they do.

Mandy Taylor stated a natural outcropping of the work done in communities is to hold regular events such as task forces and town halls. It is concerning that three-quarters of the points in the RFP process are based solely on events. The State of the Community Report, statewide advocacy, and legislative advocacy were not included in the TAY RFP in the point process. The speaker stated the need to ensure that advocates are not scored based on events but are scored on the type of advocacy that communities can be supported in.

Mandy Taylor stated the other clarification is under the RFP outline that the Commission is voting to recommend. The speaker referred to the first two bullet points under “the statewide advocacy contractor will be responsible for the following” on the second page of the proposed outline included in the meeting packet, and stated it specifies that those events need to include inviting county representatives, stakeholders, and others with the goal of informing the community program planning process. The speaker stated counties have funding to do their community planning process. That should not be the statewide advocate’s job and it is not always safe for communities to invite county representatives.

Action: Commissioner Mitchell made a motion, seconded by Commissioner Brown, that:

- *The Commission approves the proposed outline of the scope of work for six stakeholder RFPs to support advocacy, training, and outreach efforts on behalf of Clients/Consumers, Diverse Racial and Ethnic Communities, Families of Clients/Consumers, LGBTQ Communities, Parents of Children and Youth, and Veteran Communities.*
- *The Commission authorizes the Executive Director to initiate a competitive bid process.*

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Brown, Danovitch, Gordon, Madrigal-Weiss, Mitchell, and Wooton, and Chair Tamplen.

The following Commissioner abstained: Commissioner Berrick.

INFORMATION

5: <u>UCLA Community Wellness Measures and Outcomes Progress Report</u>

Presenters:

- Sheryl Kataoka, M.D., MSHS, Professor-in-Residence, UCLA Center for Health Services and Society
- Bonnie T. Zima, M.D., MPH, Professor-in-Residence, Associate Director, UCLA Center for Health Services and Society

Chair Tamplen stated the Commission will hear a project update from contractors from the UCLA Center for Health Services and Society (CHSS) on their work to develop a plan to measure key metrics of community mental wellness. She asked Brian Sala, Ph.D., to introduce this agenda item.

Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations, thanked Commissioner Danovitch for helping to frame this project. He stated the Commission, with the guidance and leadership of Commissioner Danovitch, developed a stronger understanding of options for building statewide dashboards to track various dimensions of community wellness. The MHSA emphasizes wellness and recovery. This project seeks a stronger statewide and local understanding of wellness at the population level.

Deputy Director Sala stated the MHSA prioritizes prevention and early intervention, including strategies to reduce disparities in services and outcomes, and to remove barriers to seeking services or receiving benefits. Dr. Sala welcomed today's speakers, who are two of the nation's leading experts on strategies for measuring and tracking outcomes and disparities in mental health. He noted that early draft chapters of what will become a draft report are included in the meeting packet. The intention is to get these chapters out as early as possible for a robust community response and feedback on the direction to clarify the opportunities for success in this project.

Chair Tamplen asked the representatives from the UCLA CHSS to present this agenda item.

Sheryl Kataoka, M.D., MSHS, Professor-in-Residence, UCLA CHSS, presented the preliminary findings of the UCLA Community Wellness Measures and Outcomes Project. She stated the first drafts of three chapters will be presented, which describe the data monitoring for the first three of seven negative outcomes of untreated, undertreated, or inappropriately treated mental illness: suicide, removal of children from their homes, and unemployment. She provided an overview, with a slide presentation, of the significance of tracking outcomes, populations of interest, primary objectives, and deliverables of the Community Wellness Measures and Outcomes Project.

Bonnie T. Zima, M.D., MPH, Professor-in-Residence, Associate Director, UCLA CHSS, continued the slide presentation and discussed data element draft results for the outcomes of suicide, removal of children from their homes, and unemployment; the decision points of access to care, timeliness of care, and quality of care; and next steps of the Community Wellness Measures and Outcomes Project. She stated the last four of the seven outcomes will be school failure, incarceration, homelessness, and prolonged suffering.

Commissioner Questions and Discussion

Commissioner Danovitch suggested, while thinking about how to anchor understanding of each of the indices, considering how they relate to mental illness. He stated this information can be compared between counties over time and eventually between other states across the nation to think about reasonable targets and how to inform strategies.

Commissioner Brown asked about the eligibility criteria – that they be publicly available, downloadable, and free. He stated it is difficult to find data on incarcerated individuals because it is difficult to determine how many individuals with mental illness are in jails.

Dr. Kataoka stated the eligibility criteria was generally set to take advantage of public use data and data that was easily accessible to counties. She stated Commissioner Brown's point is well taken.

Dr. Zima stated the eligibility criteria were developed in partnership with Commission staff. The UCLA CHSS trusts that staff is anticipating what the developer of that dashboard is able to work with and that the Commission wants something that can ideally be automated over time without the complications of requesting data or the involvement of the Institutional Review Board (IRB).

Dr. Zima stated, on incarceration, the annual jail survey appears to be rising to the top as a data source. It has been around since 1982 in conjunction with the Census Bureau. It has things such as number jailed and has interesting data elements about individuals on supervision like parole and receiving substance abuse treatment. These data elements will be called out that are particularly relevant, but they might require additional programming.

Commissioner Wooton referred to the Data Sources: Eligibility Criteria presentation slide where it says it includes the state of California, which may include some or all of

the counties in California. She asked if it is written this way to ask some counties but not others because some may have data on a subject and some may not.

Dr. Kataoka stated that is correct. The data that includes all counties in California would be the most valued. She stated the minimum is that they have to have state of California data, but the UCLA CHSS did not want to rule out any good data source, especially being able to compare nationally to the state of California.

Commissioner Mitchell referred to the Decision Points presentation slide and stated the Domains of Prolonged Suffering uses care as the indices – access to care, timeliness of care, and quality of care. She asked about undiagnosed care – if it had been considered and how it can be captured.

Dr. Zima stated it would be persons who have not been able to access care but need care. Not being able to access care would fall within prolonged suffering.

Commissioner Mitchell stated there are many people who are living with an illness, but they are undiagnosed.

Dr. Zima stated undetected need for care can be added. One of the challenges continued to be worked on is that these outcomes apply differentially to different age groups. That will have to be fleshed out in the chapters.

In response to Commissioner Mitchell's question on how to track individuals with mental illness who are not detected yet and are not getting services, Dr. Kataoka stated there are household surveys that ask about symptoms of mental health problems and access to service. This could be used to track people who have mental health problems but are not getting service.

Public Comment

Poshi Walker stated they are one of the members of the advisory group. Cal Voices has not provided final comments on the sections presented today but the speaker shared some of the things they will be bringing up in the advisory group. One of the issues with child welfare is that LGBTQ children are overrepresented in the child welfare system and are not very well served in the child welfare system. Children often run into the same disparities in the child welfare system as they did when they were at home. That is important to consider.

Poshi Walker stated, when it comes to suicide, there is no data on sexual orientation and gender identity from any of these statewide free sources about suicide. There is possibly more data on attempts, but it is done by the Williams Institute or Cal Voices. The speaker stated there cannot be good outcomes without good data. The speaker stated the hope that the Commission will support legislative and policy efforts in the future to get better data. Legislation may have a better chance to pass with Commission support.

Poshi Walker stated the domain of prolonged suffering is something they have been working on for the past ten years. Every survey done for LGBTQ shows that there are disparities for LGBTQ in access to care, timeliness of care, and quality of care. The speaker noted that this is especially true for rural communities, queer and trans people

of color, and non-monosexual, genderqueer and nonbinary, and transgender individuals.

Mandy Taylor stated it was heartbreaking to see the six negative outcomes and realize that the queer and trans community experiences such disparate rates in all seven of those things and, in particular, prolonged suffering. And, oftentimes, the prolonged suffering is what leads to those other six outcomes for the community. The speaker was glad that was being called out in the report.

Mandy Taylor encouraged the Commission to relook at the kind of data available at the Department of Health Care Services (DHCS) because AB 959 has just recently come into effect within the DHCS and requires the majority of departments to collect sexual orientation and gender identity data. Where that data might not have existed before, it may be available now.

Mandy Taylor echoed Poshi Walker's comments about Commission support of legislation. The speaker stated Assembly Member Lowe authored AB 650 and it unfortunately did not make it out of Appropriations Committee. Currently, when someone dies from a violent death, county coroners are required to do an autopsy and document certain things, but one of the things they are not required to document is the victim's sexual orientation and gender identity. The speaker encouraged the Commission to support future legislation so that information can be officially documented.

Executive Director Ewing stated this is part of a path the Commission started a couple of years ago of being able to make easily accessible information on funding, services, and outcomes. All three of those components will get better over time but this is a phenomenal start. He thanked the partners at UCLA and staff for their work on measures and outcomes. Executive Director Ewing stated, consistent with the comments earlier around the suicide prevention plan, the Commission is trying to track outcomes.

ACTION

6: <u>MHSOAC Conflict of Interest Code</u>

Presenter:

- Filomena Yeroshek, Chief Counsel, MHSOAC

Chair Tamplen stated the Commission will consider adoption of the proposed amendments to the Commission's Conflict of Interest Code presented at the August 22, 2019, Commission meeting. She asked staff to present this agenda item.

Filomena Yeroshek, Chief Counsel, MHSOAC, stated that under the applicable law amending the Conflict of Interest Code is a multistep process. The first step happened in August, when the Commission approved the proposed amendments. Then, it went out for a 45-day public comment period. There were no public comments submitted.

Ms. Yeroshek stated today is the last step in that process, which is for the Commission to officially adopt the proposed Conflict of Interest amendments. She reminded Commissioners that the amendments only affect who has to report and not what has to be reported on the Form 700. The amendments were necessary because the state changed job classification titles.

Commissioner Mitchell made a motion to adopt the amendments to the Conflict of Interest Code and authorize the Executive Director to submit the Code with the supporting documentation as required by law. Commissioner Berrick seconded.

Public Comment

Mandy Taylor requested that the Commission put on the agenda to discuss what the Conflict of Interest Code might look like for other individuals who work with the MHSOAC, in particular some of the local organizations. The speaker stated, when working with small communities, particularly rural communities, oftentimes the individuals who are leading the LGBTQ movement in their community are volunteers and they work for the county doing mental health work for their day job, which puts them in a bind for advocating with the county for more LGBTQ services. This is common for small communities. The speaker asked the Commission to let communities know where the conflict of interest lies for them and to provide guidance to the state around that.

Commissioner Questions and Discussion

Commissioner Anthony stated her understanding based on public comment that it would depend on the person and the department's own Conflict of Interest Code.

Ms. Yeroshek agreed. She stated the statute that the Commission is following applies to state employees, elected officials, judges, etc. There are different statutes that apply to local government employees.

Action: Commissioner Mitchell made a motion, seconded by Commissioner Berrick, that:

The Commission adopts the amendments to the Conflict of Interest Code and authorizes the Executive Director to submit the Code with the supporting documentation as required by law.

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Brown, Danovitch, Gordon, Madrigal-Weiss, Mitchell, and Wooton, and Chair Tamplen.

INFORMATION

7: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Chair Tamplen stated Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

Executive Director Ewing presented his report as follows:

ADA Compliance

Every state agency is required under the law to ensure that all online materials comply with the Americans with Disabilities Act. State agencies have struggled to do that for a variety of reasons, most due to the ability of ADA readers to interpret text on websites. Public agencies across the country are redesigning much of these materials. As a result, there have been press reports that materials are no longer publicly available because of the requirement to take them offline, fix them, and then put ADA-accessible versions back on the websites. Through this expensive and time-consuming process, it has come to staff's attention that the Commission logo is not ADA compliant online because ADA readers do not read the color yellow. The Commission's logo will need to be revisited in the future.

County Innovation Plans Approved through Delegated Authority

Much of the Innovation plan approval process has been moved into an administrative phase. Since the September 26th Commission meeting, with concurrence from the Chair, the following Innovation plans and extensions have been approved:

- Glen County – an Innovation plan on crisis response
- San Francisco County – an extension for addressing the needs of socially-isolated older adults
- San Luis Obispo County – a threat assessment program on holistic adolescent health care
    - Through this process, Chair Tamplen, in response to the San Luis Obispo County proposal, had asked them to strengthen the inclusion of peers in that work and to rethink the name to avoid the idea of re-stigmatizing individuals who may be involved in that program. The county accepted those terms.

Facilitation Opportunity

Staff will very likely be asked to partner with the University Office of the President in the coming weeks to sit down with the UC system and county behavioral health partners to support a UC system and county collaborative to improve how services are provided to students on UC campuses through partnerships with the counties, and improve the

quality of the county service delivery system in collaboration with the resources and talents that the UC brings to the table. Staff has been asked to help set up that meeting.

Project Updates

AB 1315 Early Psychosis Intervention Plus (EPI Plus)

On Tuesday, in partnership with the University of California Behavioral Center of Excellence and the National Institute of Mental Health (NIMH), On-Track New York, and other partners, staff organized a day-long event on early psychosis. Under the terms of AB 1315, the EPI Plus Advisory Board will come to the Commission with a proposal around how to allocate the $20 million that is in the Commission's budget. The meeting on Tuesday helped convey the idea about how these dollars can be used to incentivize quality improvement in the systems consistent with the three decision-point metrics – access to care, timeliness of care, and quality of care – that were identified earlier today.

Prevention and Early Intervention Project

The Commission has been directed to create, under Senate Bill (SB) 1004, a strategic initiative around Prevention and Early Intervention. The law directs counties to invest those funds into one or more of five key priorities or other priorities determined by the Commission, but it also directs that counties can deviate from that priority list, if they so choose.

Staff has been formulating a strategy under the direction of Commissioner Madrigal-Weiss. Although there is some urgency to this effort, staff has alerted the Legislature that the statutory deadline of January of 2020 will not be met because of additional necessary work. There is no penalty for not meeting the deadline.

The author's office has asked the Commission to at least communicate the terms of the legislation to the counties, clarify what the law requires, and inform them of where the Commission is in the process. Consistent with that request, staff will be sending out a letter to the counties to remind them of the standards under SB 1004, what the new language under prevention and early intervention requires, and where the Commission is in the process.

Past Projects

Criminal Justice and Mental Health

There are three multi-county projects moving forward through the Innovation Incubator focusing on strengthening the local use of data to understand who is becoming involved in the criminal justice system who might have been better served in the community mental health system, strengthening the use of psychiatric advance directives in order to support individuals who are in crisis through something comparable to a Wellness Recovery Action Plan (WRAP) that is incorporated into an advance directive, and strengthening the full-service partnerships.

In addition to that, staff helped cohost the Words to Deeds Initiative two weeks ago, which brought together over 100 subject matter experts on criminal justice and mental health.

Staff continues to work with the Legislature on these initiatives and to strengthen the understanding of the data. More funding will be made available this year to incentivize county collaboration to reduce criminal justice involvement.

UCLA will soon present a report at a future Commission meeting on how to measure criminal justice outcome data points over time.

Stakeholder Contracts

Immigrant and Refugees Communities

Staff met last week with service providers in San Diego that are serving families that are coming across the border seeking asylum, which exposed the gaps in the system of care for so many families who are at their most vulnerable in their lives. Staff will work with the Chair and Commissioner Alvarez who was the spark behind this effort to think about how the Commission can engage consistent with the funding that the Legislature provides to the Commission and the Commission makes available for advocacy on behalf of immigrants and refugees.

Commissioner Questions

Chair Tamplen referred to the ADA website compliance issue and asked for verification that federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) would have to remove the documents that they have had online, correct them, and put them back up.

Executive Director Ewing stated he did not know about federal agencies. All state agencies were directed by the Governor's Office to be in compliance with the federal law, but a number of organizations have commented that thousands of primarily historical documents are being removed from state websites because of this issue. Every agency is making choices about the time and expense that is required to update the materials before they can be put back online. This applies to the Commission, as well.

Commissioner Brown asked if ADA readers can read gold text. Changing the unreadable yellow in the MHSOAC logo to gold may be an easy fix.

Public Comment

Mandy Taylor suggested regarding partnerships with UCs and colleges in general that it is important in working with college campuses to leverage their brilliant minds, resources, and student interns and to not create programs that exclude non-college students. Many individuals are not in college because of their mental health. The speaker stated the need to ensure that any type of program or partnership with UCs that is created is open to all TAY, not just students who are already on campus, particularly because SB 10 prioritized college students. In fact, programs and partnerships with UCs can create a great open door for individuals who might not have otherwise thought of going to college to get some exposure to college ideas and campuses. The speaker

encouraged the Commission not to exclude those individuals who do not already have the resources to get to a college campus.

Commissioner Discussion

Commissioner Anthony stated the Commission website can be difficult to navigate and causes confusion. She provided the example that meeting minutes are not located in one section but must be searched, but the search results are too broad. She suggested including some kind of a priority so it has a logical, sequential query ability so that individuals who want to look at the minutes, agendas, or other items for subcommittees can locate them without a lot of confusion.

Commissioner Berrick thanked staff for coordinating the Immigrant and Refugee Forum held in San Diego last week. It dramatized the need and was enlightening. He suggested that family therapy might be a necessary service for families that were separated forcibly at the border. There is a long way to go in engaging and undoing some of the damage that has been done. He encouraged the Commission to stay focused on the immigrant and refugee issue.

GENERAL PUBLIC COMMENT

Sharon Ishikawa, MHSA Coordinator, Orange County, thanked staff and the Subcommittee that worked on the Suicide Prevention Strategic Plan. It is extremely timely and meaningful. The way it is structured is actionable. The speaker gave a commitment from Orange County that, while it may not be required to implement it, Orange County will use the Suicide Prevention Strategic Plan as a guiding document. The speaker stated Orange County will tie their work into this road map that has been laid out.

Sharon Ishikawa stated there was a question about how to increase the visibility of the Suicide Prevention Strategic Plan. The speaker invited the Commission to present the Suicide Prevention Strategic Plan in Orange County and to partner with the different agencies, work groups, and populations within Orange County. This way, the guiding principles and road map of the Suicide Prevention Strategic Plan can be tied into the local work and efforts.

Poshi Walker clarified that their request for pushing back the RFP timeline for the Stakeholder Advocacy Contracts is that the holidays are a stressful time and responding to the RFP adds to that stress. Every one of the stakeholder contractors are from populations that are already distressed and the holidays, especially with family, can be difficult. The timeline as written creates a burden on applicants' mental health. The speaker asked to postpone the deadline for the RFPs to allow applicants to fully focus on the holidays, their mental health, and their proposals.

Sally Zinman echoed the comments of the previous speaker. The speaker noted that, it is not that the applicants will not do the work, it is contacting individuals throughout many counties to try to get responses in December.

Sally Zinman spoke as a representative of the older adult community. The speaker stated they spoke three years ago during the first round about including the older adult

community in the Stakeholder Advocacy Contracts. This is now the second round, and the older adult community is still left out of the Commission's stakeholder advocacy groups. The speaker stated the need for the older adult community to be included in the Commission's Stakeholder Advocacy Contracts.

Brenda Scott, NAMI Mt. San Jacinto, thanked the Commission for their ongoing support for families and individuals across the state. The funds that are provided through the programs provide critical and crucial resources for communities to deliver programming that is not just client and family driven but ensures better outcomes for family members and individuals. The speaker stated they are a Family-to-Family teacher and state trainer and they see the difference it makes in people's lives. NAMI appreciates the support of the Commission and strongly supports the proposed framework that includes both the state and local scope of work as developed by community stakeholders. This approach will allow NAMI to continue to serve families and individuals across the state.

ADJOURN

Chair Tamplen thanked Jorge Campos for joining the Commissioners around the table at today's meeting.

Jorge Campos thanked the Commission for inviting him to be a part of the Commission today and to hear the good information.

Commissioner Wooton thanked Chair Tamplen for her leadership throughout this year and the changes she has brought forth.

Chair Tamplen thanked everyone for their participation and support and adjourned the meeting at 3:45 p.m.

STAFF ANALYSIS – EL DORADO COUNTY EXTENSION

Innovative (INN) Project Name:	**Community Based Engagement and Support Services (aka HUBS)**
Extension Funding Requested for Project:	**$2,158,704**
Time Extension Requested for Project:	**9 months**

Review History:

MHSOAC Original Approval Date:	**August 25, 2016**
Original Amount Requested:	**$2,760,021**
Duration of Innovation (INN) Project:	**Four (4) Years**

Current Request:

County Submitted Final INN Extension:	**November 4, 2019**
Approved by BOS:	**June 25, 2019**
MHSOAC Consideration of INN Project:	**January 23, 2020-Consent**

Project Introduction

This project from El Dorado County was originally approved by the Commission on August 25, 2016 for up to $2,760,021 in innovation spending authority. The original project intended to promote interagency collaboration and partnered with County Public Health, the First 5 Commission and the County's Health and Human Services Agency by developing and placing five community hubs in local libraries within the County with the goal of increasing physical and mental health care access for families, pregnant women, and children from birth through 18 years of age. The hubs were developed to offer mental and physical health prevention activities such as support groups, education classes, engagement opportunities, screenings for mental health, alcohol, and drug and referrals were offered as needed.

Although the project was approved in August 2016, the project did not start until May 1, 2017. The County indicates this nine-month delay occurred due to normal County processes. Subsequent to Commission approval, the County's Board of Supervisors had to create and approve the positions that were needed to implement the project. County Human Resources then had to create duty statements for all the required positions and

then County Behavioral Health interviewed, selected candidates and completed required background checks and pre-employment screening.

The County is requesting an additional amount of $2,158.704 in innovation spending authority along with a nine-month time extension to address challenges, explained in detail below, the County experienced in relation to staffing, technology, and the analysis of data and reporting. To address these challenges, the County would like to incorporate additional personnel and upgrade the technological needs for project staff which would allow for continued learning in this project. The County wishes to address these barriers in order to adequately meet their original learning objectives.

Reason for Extension The original project was developed as a result of a Maternal, Child, and Adolescent Needs Assessment and Action Plan which revealed that El Dorado County residents had a high rate of mood disorder and substance use hospitalizations in pregnant women and youth between the ages of 15-24 years of age. Community hubs were developed and placed in five libraries within the County with the goal of engaging isolated pregnant women, families and children and providing health navigation and referrals to community based mental health services as needed.

Following the implementation of the project, the County began to experience challenges that if not addressed, would interfere with the overall learning objectives that were established. The four identified challenges were in the following areas:

1. Staffing
2. Limited Family Engagement Staff
3. Technology and infrastructure
4. Analysis of data and reporting

Staffing:

El Dorado County originally hired five Public Health Nurses as limited term positions, as opposed to full-time positions, and as a result experienced a high rate of staff turnover. The County had a difficult time retaining Public Health Nurses in these positions as most employees in that position desired a full-time position and would vacate the limited term positions once a more permanent position was available.

Proposed Solution:

As a result, the County restructured those limited term, full time positions to permanent, full time positions which helped to lessen staff turnover. This change highlighted the need for a full time Public Health Nurse Supervisor. As part of the original project, the County onboarded a part time (0.20 FTE) Public Health Nurse Supervisor; however, the County realized this position that in order to allow for adequate program oversight, supervision and interagency collaboration, this position should also be full time. **Additional funding for a full time Public Health Nurse Supervisor is being requested as part of this extension**.

Limited Family Engagement Staff:

The current project has a part-time Family Engagement Staff located at each of the five hubs. The primary purpose of the Family Engagement Staff was to work with families and community agencies to support the developmental needs of children age birth to five years old. Research indicates the quality of relationships early on is important for lifelong mental health and affect in the first few months of life is linked with the effects of the primary caregiver (Klitzing, K, et al, 2015).

The part time Family Engagement Staff were able to provide developmental screenings for 300 children and engage 797 adults in developmental activities during the last fiscal year which resulted in a decrease in social isolation and positive interaction within families; however, the part time Family Engagement staff could only provide screenings for children up to five years of age. The County states that increasing Family Engagement Staff to full time positions would allow an additional 150 developmental screens annually and would permit Family Engagement Staff to work with children and young adults up to the age of 18.

Proposed Solution:

The County states that increasing the Family Engagement Staff to full time positions within each hub would increase the amount of developmental screenings offered with special focus on school engagement and would also allow Family Engagement staff to work with individuals and families with children up to up to 18 years of age. The County states the expansion and availability of Family Engagement Staff would allow greater partnerships with the schools and facilitate working with the families of children who may be experiencing challenges in school that may negatively affect and/or impact a child's wellbeing and resilience later in life. In order to provide supervision and review of the Family Engagement Staff, the County would like to onboard a part time (0.10 FTE) Family Support Coordinator who will observe and provide support for the five full time Family Engagement Staff. **Additional funding is being requesting to convert the current part time Family Engagement Staff, located in each hub, to full time positions along with the onboarding of a part time (0.10 FTE) supervising Quality Improvement and Family Support Coordinator.**

Infrastructure and technology:

Some of the community hubs have unreliable internet connectivity, or may even have non-existent internet connectivity, making the entry of data cumbersome and may result in the loss of data. Currently, the Public Health Nurses utilize a tablet which is not efficient in terms data storage. Additionally, the Public Health Division within El Dorado County maintains patient and client electronic health records utilizing Patagonia Health; however, the Public Health Nurses store data in a software program other than Patagonia so data is captured through a separate software program which does not allow the consolidation and accessibility of patient data for case management and referral for various services within the community.

Proposed Solution:

The County would like to upgrade to laptops which are capable of much larger data storage capacity and will also allow data entry into appropriate software programs until data can be successfully uploaded with strong network connectivity.

The County would also like the Public Health Nurses to store data within the Patagonia software program which would allow more effective case management and running of reports for program success without the possible duplication of data entry and data error. **Additional funding is being requested to upgrade from tablets to laptops to minimize loss of patient data due to inconsistent internet connectivity along with additional licenses to utilize Patagonia software to allow proper maintenance and security of electronic health records.**

Data Analysis and Reporting:

This project involves the collaboration and partnering of various community partners providing assessments, linkages, and services to individuals which results in the collection of data, analysis, and outcome reporting. Historically with this project, each of the collaborating partners have captured data relative to their specific funding stream which has led to variations in the way data has been collected and analyzed, along with the analysis of the data which has been completed by the Public Health Nurses. Inconsistent data has been a concern expressed by stakeholders as a barrier in terms of the final evaluation of this project.

Proposed Solution:

The County proposes to acknowledge the concerns expressed by stakeholders by onboarding a Senior Analyst who will be charged with the evaluation of the data. The County indicates a single point of contact to evaluate the data would increase the reliability, including the possibility of increasing collaboration with all partners to explore requirements consistent to gathering data. **The County is seeking additional funding to bring in a Senior Analyst who will be responsible for the evaluation component of this project and coordinating a more cohesive partnership.**

The Community Program Planning (CPP) Process

The original project was created out of stakeholder input provided during the Fiscal Year 2016/2017 Annual Update which yielded feedback to proceed with development of the original innovation project. For this extension, El Dorado County held their 30-day public comment period beginning April 19, 2019 followed by their Mental Health Board public hearing on May 22, 2019. Board of Supervisor approval was received on June 25, 2019.

The County sought input from their stakeholders via several community meetings held during the day and evening to solicit robust feedback. The meetings were attended by 121 individuals who provided input regarding the County's innovation projects. The County also distributed surveys to solicit stakeholder feedback for the Fiscal Year 2019/2020 Annual Update, including this innovation project. A total of 302 surveys were received in response. Additionally, the County's Mental Health Services Act (MHSA)

Division attended the County's Health and Human Services Open House and obtained a booth where approximately 250 members of the community stopped and inquired about various MHSA programs and innovation proposals.

The Community Hubs project leads were invited to update the Behavioral Health Commission at their April 2018 and April 2019 meetings. The community was also updated on the status of the Hubs project and the challenges the County had encountered during its implementation.

Commission staff originally shared this project with stakeholders on May 14, 2019 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared with stakeholders on November 8, 2019. No letters of support or opposition were received by Commission staff as a direct result of the sharing of this project with stakeholders on the two dates referenced above; **however**, there were three letters of opposition that were submitted (two of those three letters were from same individual), along with 27 letters of support submitted by community partners in the County. One letter of opposition was received on May 9, 2019, he second letter of opposition was received on July 29, 2019, and the final letter of opposition was dated August 12, 2019. (*Note: letters of opposition and support will be included as part of the Commissioners packets. Permission has been granted from those who wrote letters of opposition to be included and they have waived their desire to remain anonymous*).

The letters of opposition reflected concern surrounding the possibility of reverted funds being returned to the County and the need for these funds to support other behavioral health concerns in the county.

As part of MHSA General Standards, El Dorado County will depend upon community collaborations and stakeholder feedback during all phases of this project. The County intends to utilize culturally and linguistically appropriate staff to engage individuals within the community hubs. This project is client and family driven where individuals and families can engage in programs of their choice and seek services as needed with emphasis based on recovery, wellness, and resilience.

Learning Objectives and Evaluation

The learning goals, questions, and methods that will be used to evaluate the HUBS program remain unchanged. Additionally, the El Dorado County will continue to target individuals of all ages in the County, with attention given to geographically isolated families and pregnant women. Overall, the County hopes to learn if the impact of the HUBS approach can lead to increased access to services. Additional expected learnings revolve around the project's impact on reducing mental health costs, increasing client screenings and treatment for MH services, and whether the trauma-informed approach can assist in reaching clients deemed to be "hardest" to serve.

While the limitations noted in the extension request have delayed the project overall, early learnings from the project indicate that there has been an overall increase in referrals received and client contacts, suggesting that clients are willing to access community hubs

within libraries. The County also notes that the true impact this has on mental health services overall is yet to be determined as they continue gathering data and evaluating the program and is seeking an extension of time and funding to allow for the thorough analysis of the learning objectives with the increase in staffing and improved technology support.

The overall evaluation plan remains the same, however, it is laid out more methodically with more thought given to measurements that will be used to explore each learning objectives. Data will continue to be collected by tracking referrals and client contacts, linkages made, as well as through various tools administered by public health nurses, such as the Family Strengthening Protective Factors Survey and various other screening tools (**see pgs15-16 of County plan**). One consideration missing from the evaluation plan is **how a baseline will be established upon which data will be compared, and how often surveys will be administered** to better understand client satisfaction and increased knowledge among staff. At the conclusion of the program, the County will share lessons learned and findings at various local meetings, as well as via the county's Health and Human Services Agency Facebook pages and other webpages.

Keywords: Community Hubs; mental health screening in libraries; community health advocates in libraries; adverse childhood experience study; community hubs; mental health screening in rural communities.

Budget

The original project was approved for $2,760,021 in innovation funding in August 2016 for a duration of four years. This extension request is seeking an additional $2,158,704 in innovation funding with an extension of time of nine months, not to exceed the five-year innovation project regulatory timeframe. Personnel costs total $1,234,882 to cover the additional position of a supervising public health nurse (1.0 FTE), a senior analyst (1.0), contracted family engagement staff (2.50 FTE), and a supervising family support coordinator (0.10 FTE). Operating costs (which include indirect and direct costs) total $171,989 and will cover items associated with travel expenses, network fees, communications and rent. Non-recurring costs in the amount of $120,000 (5% of extension request) includes technology needs such as laptops, docking stations, wireless cards and other technology-related needs which will assist in addressing the challenges relative to data gathering. The County will be contracting with the County Office of Education in the amount of $611,033 for the provision of personnel serving as Family Engagement Specialists. Evaluation for this extension project totals $18,300 and administrative costs will cost $2,500.

The County is leveraging a total of $1,139,710 from in-kind funds and other funding sources (Public Health MCAH Funds, First 5, El Dorado County Office of Education). The total cost of this project is $3,298,414 which includes innovation funding and various other funding sources (see page 29 of project plan for listed funding sources).

Pursuant to AB114, the County states they will utilize funds subject to reversion first until no reversion funds are available. Regarding sustainability, the County may continue with

this entire project or components of this project, including personnel, with either Community Services and Supports funds or Prevention and Early Intervention funding.

Additional Regulatory Requirements

The proposed project (extension) appears to meet the minimum requirements listed under MHSA Innovation regulations**.**

References

Klitzing, K., Dohnert, M., Kroll, M., Grube, M. Mental Disorders in Early Childhood, May 2015; 112(21-22): 375–386. Retrieved on December 20, 2019 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4496484/

https://www.thewholechild.org/parent-resources/age-0-5/normal-development-stages-ages-0-5/

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☒ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☒ Local Mental Health Board approval Approval Date: 5/22/19
☒ Completed 30 day public comment period Comment Period: 4/19/19-5/19/19
☒ BOS approval date Approval Date: 6/25/19 If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: __ *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: Dec. 2019 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

County Name: El Dorado County

Date submitted: 8/16/19

Project Title: Community-Based Engagement and Support Services

Total amount requested: $4,918,725 (Original Innovation Plan approved $2,760,021)

Note: Due to slower than anticipated implementation and challenges faced during implementation, the actual expenditures have been lower than budgeted. See page 28 for more detail about total expenditures vs. budgeted expenditures.

Duration of project: Modification: 9 months, the project will end June 30, 2021

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☒ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

The existing Community-Based Engagement and Support Services ("Community Hubs") Innovation project was approved by the MHSOAC in August 2016. The project began implementation on September 19, 2016, and direct services to clients began May 1, 2017. Although the Community Hubs are regarded by stakeholders as a valuable community program, the success of the underlying purpose of this Innovation program ("Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes") has not yet been determined.

Following implementation and with ongoing administration of the Community Hubs, MHSA and the service partners have identified some programmatic challenges, which, if addressed, would enable continued learning, and if not addressed could negatively impact the County's ability to fully analyze the learning objectives from this Innovation program.

Identified challenges include:

1. Staffing challenges;
2. Limited Family Engagement Staff;
3. Infrastructure and Technology; and
4. Data Analysis and Reporting.

In reviewing the existing Community Hubs project and the challenges presented, El Dorado County, in conjunction with stakeholders, prioritized modifications of this project to address the identified challenges.

This request is for an extension of time and funding for this project to allow for adequate implementation and evaluation, as well as to ensure the learning objectives can be evaluated.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

El Dorado County MHSA proposes to expand the existing Community Hubs in order to attempt to resolve emergent challenges, and to continue learning if the Community Hubs model of interagency and community collaboration will result in an increase in early mental health care access for pregnant women, families, and children ages birth through 18 years, resulting in a reduced number of mental health issues, substance use issues, family violence, and high risk pregnancies.

The Community Hubs access funding through several sources and thus while the Community Hubs are not solely focused on mental health needs, the MHSA funds are focused on helping the community access mental health services and preventing challenges that individuals and families may experience that could lead to the need for mental health services in the future.

The Adverse Childhood Experience (ACE) Study is one of the fundamental foundations of this Innovation project and this modification request. The ACE Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. It showed how childhood trauma is linked to the adult onset of mental illness, substance use, chronic disease, violence and being a victim of violence. In the 1998 ACE Study, conducted by the Centers for Disease Control and Kaiser Permanente, researchers discovered that of the over 17,000 participants, 64% had an ACE score of one (1) or more and 12% had an ACE score of four (4) or more. The researchers also found that the higher a person's ACE score, the greater the risk of mental illness and chronic disease. For example, compared with someone who has an ACE score of zero (0), a person with a score of four (4) is 2 times more likely to be a smoker, 7 times more likely to be an alcoholic, and with a 1,200% increase risk of attempted suicide. Individuals with an ACE score of six (6) or higher have shorter lifespans – up to 20 years shorter.

In El Dorado County in 2011-12, results from the ACE Screening Tool show that parents reported that 18.2% of children in their care had experienced two or more ACEs. An estimated 42.7% of adults in El Dorado households report being exposed to one (1) to three (3) ACEs when they were children and 20.7% report being exposed to four (4) or more ACEs when they were children.

In addition to childhood trauma, there are other types of pervasive toxic stress. A 2013 report by the Family Health Outcomes Project found that El Dorado County exceeds the state average in key precursors to toxic stress. The report notes that compared to the statewide average, El Dorado County has two and a half times greater mental health diagnoses in pregnancy and nearly double the statewide average of substance affected still or live born infants per 1,000.[1] Further, the California Health Interview Survey reports that El Dorado County has 9.6% of adults with likely serious psychological distress, compared to a statewide value of 8.2%.[2]

Knowing that El Dorado County residents have been exposed to ACEs and other forms of toxic stress, and that some residents may have genetic predisposition to mental illness, this Innovation project seeks to continue to explore if bringing together a team of health specialists, family engagement specialists, and literacy specialists to offer case management, services, referrals and linkage to services, and activities in a neutral, non-stigmatizing setting, will help build a resilient community. This is and will continue to be done utilizing the Center for the Study of Social Policy's Strengthening Families Protective Factors Framework as the foundation for the program. This Framework has shown to increase resiliency within clients in a variety of settings.

Since implementation of this program, the libraries remain an important access point for the "Community Hubs". However, other spaces where families naturally meet, including schools, apartment complexes, and community events have evolved into additional access points in keeping with the purpose of this Innovation program to promote interagency and community collaboration.

Evaluating Community Hubs project data gathered during the evaluation period of May 1, 2017 to June 30, 2017, compared to data gathered during the evaluation period of July 1, 2107 – June 30, 2018, shows an overall increase in the referrals received and client contacts.

[1] http://www.welldorado.org/index.php?module=indicators&controller=index&action=view&indicatorId=6427&localeId=246

[2] http://www.welldorado.org/indicators/index/view?indicatorId=85&localeId=246

Data Measure	Overall count for period of May through June 2017	Overall count for period July 2017 through June 2018	Difference
Hub referrals received and assigned	41	188	+147
Community Health Advocates linkage requests	140	276	+136
Home visits or significant contact with Public Health Nurse (PHN) or Community Health Advocates	168	1,697	+1,529

Referrals made from Public Health Nurse staff to:	Overall count for period of May through June 2017[3]	Overall count for period July 2017 through June 2018[4]	Difference
Mental Health Services	**14**	**48**	**+31**
Services Received	4	17	+13
Primary Care Physician	**14**	**101**	**+87**
Services Received	7	55	+48
Dental Provider	**46**	**232**	**+186**
Services Received	5	170	+165
Insurance Coverage	**13**	**236**	**+223**
Services Received	3	104	+101
Developmental Services	**7**	**12**	**+5**
Services Received	1	2	+1
Other PHN programs	**3**	**19**	**+16**
Services Received	0	6	+6
Other Community-Based Resources	**47**	**176**	**+129**
Services Received	13	60	+47

[3] For "services received" in 2017, this term means that the client completed an appointment with a provider only and does not reflect clients that had an appointment scheduled at the time of discontinued follow-up.
[4] For "services received" in 2018, the client completed an appointment with a provider OR had an appointment scheduled at the time of discontinued follow-up.

In summary, the data gathered during the evaluation period of May 1, 2017 to June 30, 2017 compared to July 1, 2107 to June 30, 2018, shows an overall increase in the referrals made and services received. However, it is believed that, overall, the data measures are underrepresented due to staffing challenges, technology challenges, and lack of standardized data dictionaries and protocols.

Addressing these challenges by expanding the MHSA Community Hubs Innovation project is anticipated to resolve the challenges and contribute to greater learning.

Challenge: Staffing Challenges

Having consistent Public Health Nurses available to the community is vital to the mental health of the unserved and underserved members of our community. The Public Health Nurses are intended to serve as a health team lead in Community Hubs, providing direction and guidance to Community Health Advocates and consultation partners.

One of the first challenges faced by this program has been inconsistent staffing. The Public Health Nurse allocations associated with this program were initially deemed "limited-term" allocations, meaning a position is filled to accomplish a specific project that is limited in duration, is not of a recurring nature, and will continue for a period of six months or more.

Hiring and retaining qualified individuals is extremely time-consuming and challenging. Recruiting, interviewing, hiring, and training Public Health Nurses is time-intensive. However, candidates who accept the offer of "limited term" employment, continue to search for more permanent employment and resign from the limited-term Public Health Nurse position in favor of a permanent position. Thus the cycle of recruiting, interviewing, hiring, and training is again initiated. Additionally, because the position is a limited-term allocation, it is difficult to attract and recruit qualified individuals.

Low staffing levels also affects program consistency and staff morale. The fact that staff turn-over has been a recurrent issue means opportunities for job shadowing and mentoring are reduced. Consequently, training time is limited before employees are expected to independently assume the duties expected. Staff morale is then affected due to the turn-over. Staff morale also is affected when leadership is consumed with training new employees, thus leaving little time for team building, ongoing training, and program oversight. Creativity with programming and problem solving also is hampered when the focus is on training new staff. Interagency collaboration is also impeded.

Restructuring the Public Health Nursing staffing to accommodate regular (not limited term) status positions has alleviated some of the staffing turn-over and resulted in a consistent workforce that is knowledgeable of local resources, practices and clients.

However, although the Public Health Nurse staffing levels have largely been resolved, there is a need for a full-time Public Health Nurse Supervisor to provide program oversight and supervision of the Public Health Nurses. The current allocation is 0.20 full-time equivalent (FTE). This allocation is not adequate to perform all the functions of this role, as well as to oversee the outcome reporting required for this program. Changing this allocation to a 1.0 FTE would contribute to greater program oversight, supervision, and interagency collaboration.

If this program is shown to be successful, long-term sustainability of the Public Health Nurses and Public Health Nurse Supervisor will be funded through other funding, grants, and funding partnerships, potentially including MHSA Community Services and Supports (Outreach and Engagement) or Prevention and Early Intervention funding. It is also anticipated that a natural attrition rate will occur.

Challenge: Limited Family Engagement Staff

Another challenge has been identified with the Family Engagement staff. Current funding supports 0.5 FTE Family Engagement staff at each Community Hub. The Family Engagement staff work with parents, guardians, families, and community agencies to support practices and approaches which meet the developmental needs of children age birth to five years old. The current 0.5 FTE Family Engagement allocation has shown to limit programming availability. The expansion to 1.0 FTE Family Engagement staff at each Community Hub will facilitate building stronger partnerships and relationships within the Community Hub communities, including local schools, and increase family, school and community engagement. The school partnerships will reach more families with children who are experiencing psycho-social and parenting challenges that impacts childhood health, development, and literacy, as well as school attendance and engagement, all of which can impact a child's resiliency. This early intervention with families helps to build resiliency by connecting families to Community Hub services and establishing supportive community relationships. Additionally, increased funding for the Family Engagement Specialist allocation will permit working with individuals and families ages birth to 18 years old.

In Fiscal Year 2017/18, the original 2.5 FTE Family Engagement team (not funded through MHSA), provided developmental screening to 300 unduplicated children and engaged 797 adults in developmental play and learning activities, decreasing social isolation and increasing positive adult interactions with their young children. By expanding to a full FTE Family Engagement Staff per Hub, we anticipate an additional 150 developmental screens annually and increasing our family engagement programming with special focus on school engagement.

To support the staffing needs of the Family Specialists, there also is a need for a 0.10 FTE supervising Quality Improvement and Family Support Coordinator. This supervising position provides monthly observation of the Family Specialists and

review of the programming strategy and performance as it relates to Family Engagement.

Challenge: Infrastructure and Technology

As identified in the Fiscal Year 2016/17 Innovation outcomes report, technology has been a challenge for this project. Several factors have contributed to this issue, including lack of strong wireless signals in areas of the County and the use of separate, and very manual, record keeping systems.

Internet connectivity is an issue in some of the Community Hubs. The internet connection is unreliable or non-existent. For example, some staff experienced loss of data related to entries made using Wi-Fi that had lost the connection to the secure County network. Additionally, staff use tablets, which have proven to be too small for the amount of information required to be collected, or, in some cases, the tablets did not work in the field. If the tablets were replaced with laptops, it is believed that laptops would be more reliable and practical, and minimally allow staff to enter data into Microsoft Office products installed on the laptop rather than a cloud-based system. This would also resolve the network connectivity issues because information would be saved on the laptops for future data uploading when network connectivity is strong.

Additionally, Health and Human Services, Public Health Division currently uses proprietary software called “Patagonia Health, Inc.” (Patagonia) to maintain patient electronic health records (EHR) and practice management with Patagonia’s secure network. However, data collected by the Public Health Nurses for the Community Hubs program is captured through a separate process.

Integrating the Community Hubs Public Health data into Patagonia will increase the ability to more effectively provide case management services to clients, provide health-related referrals through the EHR, reduce the amount of double entry that is needed (and thereby reduce errors in data entry and analysis), and develop reports to provide the needed data to further evaluate the program. Migration to sole use of Patagonia will result in increased use of Patagonia’s software, so there would be an additional maintenance cost.

Challenge: Data Analysis and Reporting

As an interagency collaboration program, the Community Hubs program requires capturing and reporting a significant amount of data and reporting outcomes. Currently, staff within each funding stream capture and report data relative to their funding requirement. This leads to some duplicative data collection, as well as inconsistencies in the way data is collected and/or interpreted. These data challenges are a barrier to effective interagency collaboration and stakeholders have identified lack of data as a concern for the effective ongoing and final evaluation of this program.

The function of data analysis has largely been placed upon the individual Public Health Nurses and Public Health Nurse Supervisor, taking valuable time away from program operations and staffing supervision. This function could be more effectively managed by a Senior Analyst, who requires less supervision and instruction, or by an Analyst, who requires some supervision and instruction.[5] Assigning data analysis and reporting to one individual, who is responsible for evaluations performed for this program, also would increase the reliability and availability of the data. Additionally, an Analyst could assist with improving the collaboration between the entities by exploring and establishing comprehensive data needs.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

The modification of this program does not change the original general requirement of this project, which introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

As with the initial Innovation project, this modification request incorporates the concept of a "Hub". The term "Hub" is used in the Oregon Early Learning Model, but it does not have the same definition we are using in this project. In 2011, the Oregon Legislature approved the Governor's vision to create a "seamless education system from birth through college".[6]

Built into the Oregon Model are the principles that all children are school ready, and families are healthy and stable. Each area of the state is able to develop their "system" based on the community need and the identified primary partner. The model does not have a one-stop shop, but instead relies on the partnership of schools and primary care clinics to complete assessments for school readiness, developmental milestones, and overall health.

El Dorado MHSA's connection to the Oregon Model is in the collaboration between agencies, through a "Community Hub." By definition, the Community Hub mission is to "build resiliency with families through collaborative, community-based prevention and early intervention services".[7] Built into the concept of the Community Hub is community – people get together to work, learn, and grow through supportive

[5] The exact County job classification name has not yet been determined pending the outcome of the County's Compensation and Classification Study which may result in the renaming/reclassification of certain positions. Therefore, the duties of this position would be equivalent to those of a Senior Department Analyst or Department Analyst as they exist under current County job classifications.

[6] https://oregonearlylearning.com/administration/about-us/what-we-do/#history.

[7] https://docs.wixstatic.com/ugd/ee4161_5232d895bf2e47e39dc46766346931d5.pdf

relationships. Foundational to a community must be a belief and understanding that people can help and serve one another in both formal and informal ways. They can help strengthen and connect a community by providing opportunities for people to work together and support each other in new ways. El Dorado County Community Hubs are designed to offer services to build resiliency by offering opportunities for active skill building, connection to resources, and case management.

Community Hubs teams have been established at libraries located in the five (5) supervisorial districts within El Dorado County, and services are provided not only at the libraries but also where residents live, attend school, engage with other community members, and other locations appropriate to the services provided in response to stakeholder and client input that greater access to the Hubs staff be available.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

In Fiscal Year 2017/18, the Hubs served 646 total individuals. Data for Fiscal Year 2018/19 is not yet available. It is estimated that the Hubs will continue to serve approximately the same number of individuals on an annual basis, however it would be hopeful to have the number increase. The data is derived from the data collection at each Hub site, subject to the challenges noted above. The number of referrals and linkage to mental health services is also identified above.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The target population is geographically isolated families, pregnant women, and children age birth through 18 years old. There are 23,856 households (31.76% of households) in El Dorado County with children. Most of El Dorado County is Caucasian (78%) and 13% is Latino. English is the primary language, but services will be provided in Spanish as needed, with Spanish being the County's only threshold language. Approximately 40% of the Community Hubs staff is bilingual. Services will be provided without regard to sexual orientation, gender, or other demographic characteristics.

All services will be provided in a culturally competent manner based upon the needs and preferences identified by those being served.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The Community Hubs project promotes integration of successful service delivery models in the early childhood, health, and community building systems

to provide a local continuum of care for pregnant women, families, and children birth through eighteen, including increasing access to mental health services. Key elements of the Community Hubs include:

Community-Based Access: The Oregon Model relies on a partnership of schools and primary care clinics to complete assessments to ensure school readiness for children. El Dorado County's model is similar with regards to community collaboration, but unlike the Oregon Model, El Dorado County's project establishes "hubs" – a one-stop-shop type of approach. Community Hubs are centered in the libraries in each of the five (5) supervisorial districts in El Dorado County. Since the Community Hubs program was implemented, service locations have expanded beyond the libraries and now include places such as apartment complexes, schools, and community events. By offering assessments and services at places where individuals and families naturally gather, we are able to provide an array of services while reducing the stigma associated with seeking mental health services.

Outreach to Isolated Communities: The Community Hubs engage pregnant women, families, and children, primarily age birth through 18, in isolated regions of the county using the Community Health Works Model. Community Health Advocates (CHAs) assist community members to increase access to care by using best public health practices in performing a variety of community outreach and education functions. As a trusted community partner, CHAs can offer linguistic and cultural translation; provide linkage and access to services; and develop relationships in a community setting, including communities in geographically isolated areas of the County. The CHAs act as a liaison between the community and the Public Health Division for improved service delivery.

Continuum of Care: The Community Hub partners develop trusted relationships to assist community members in assessing and developing an individualized plan, and in case management. Each Community Hub partner plays a vital role in the continuum of care, with the Public Health Nurses focusing on populations at risk needing interventions to address the prevention or amelioration of high risk conditions, whether it is chronic illness or mental health needs. The Public Health Nurses use a trauma-informed approach to provide services including, but not limited to, case management; health screenings and assessments; mental health screenings; and alcohol and drug screenings. Through establishing a connection with individuals and families, the Public Health Nurses are able to broach subjects, such as mental illness, that otherwise may not be addressed through one-time or more casual contacts.

Community Input: Ongoing, local input from stakeholders promotes continuous quality improvement in service delivery by engaging community members in determining successful implementation.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

This project is seeking a modification of the previously approved Innovation program to address challenges that have been a barrier to learning.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

The initial question was "will a library-based access point for services, different than the multi-access point of the Oregon Learning Model, facilitated by a Public Health Nurse using trauma-informed approach, be successful in the rural areas of the County?" In this case, "successful" is a reflection of community members, especially in the more isolated areas of the County, visiting the Hubs and inquiring about, seeking, and engaging in services. Success can be defined as any combination of inquiring about, seeking, and/or engaging in services.

This Innovation project has been operational for about two years. Despite the challenges previously discussed, anecdotal reports and limited data conclude that individuals are willing to access Community Hubs in the libraries; however the impact to mental health services is not yet fully understood.

Additionally, while this project brings together multiple agencies to improve collaboration, there is insufficient time and data to determine the effectiveness and long-term (being the full length of the program) success of the collaborative process. Measurements of success may include:

- Community Hubs staff, along with other employees of their agencies, are able to build relationships with and expand knowledge of other community agencies, thus providing more whole person care rather than each agency addressing only a single aspect of a person's life.
- Increased sharing of knowledge and resources.

- Visitors to the Community Hubs receive a soft handoff to programs and services, thus helping to ensure that the visitors receive the services and support needed.

Without this interagency collaboration, each agency would continue to be operating in silos and the visitors to the individual agencies may be less likely to follow through with access, linkage, and referrals to other agencies. As with most agencies, each focuses on their specialty, and absence the physical presence, in the same building or space, referrals to other agencies is often forgotten. For example, County Behavioral Health staff is not present in the Hubs, however, due to interagency collaboration, the Public Health Nurses made 48 mental health referrals during fiscal year 2017/18. It is difficult to quantify how many of those 48 referrals would have contacted County Behavioral Health if they were not referred through the Hubs. It is even more difficult to identify the number of referrals that were prevented due to the intervention of the Community Hubs teams.

Community Hub client satisfaction surveys indicated that 23 percent of participants experienced gains relative to parental resilience, 28 percent of participants experienced gains relative to the child's social and emotional security, both of which demonstrate growth in protective factors that may prevent the future need for mental health treatment.

With limited data availability due to the shortened period of implementation as well as staffing and infrastructure challenges previously discussed, we propose that addressing these challenges will enable this project to have stability to complete evaluation.

Additional questions from the original Community Hubs project:

- Does providing services at the library reduce stigma?
- Does increasing access to prevention and early intervention reduce long-term mental health costs?
- Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?
- Does case management by a Public Health Nurse, increase client screening and treatment for mental health services?
- Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?
- Can Community Hubs be sustained through local planning and leveraging of resources?

Due to the multiple community partners and the fact that the Community Hubs are geographically spread throughout El Dorado County, these goals were prioritized to examine both the effectiveness and the sustainability of this

project. As the project continues, other learning goals and objectives may be identified.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The learning goals directly relate to the unique aspect of providing mental and physical health services in a community setting where individuals and families naturally congregate.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Client level data will be collected via Community Health Advocates, Public Health Nurses, and Family Engagement Specialists. Data collected is anticipated to be, minimally, the number of clients served, type and amount of screenings performed, specialty health referrals made and to whom, and the number of clients who accessed these services.

Program level data will be gathered by funding partner First 5. As previously mentioned, this data will be gathered through the Family Strengthening Protective Factors Parent Survey to better understand family resiliency. Additional data analysis and reporting will be provided by the expansion-funded Analyst.

Hub leadership will be convened on a regular basis to better understand service impact, access and barriers to services; and quality improvement; team meetings will be held to better coordinate care and services; and periodic community-based focus groups will be convened to gather input from stakeholders.

Qualitative data will be combined with county quantitative data to provide a better understanding of community need and provide a continuous quality improvement process. These data profiles will guide program implementation.

Learning objective #1 - Does providing services at the library reduce stigma? The following indicators will be measured:

- Tracking referrals received and client contacts.
- Linkage by type and source (e.g., mental health/dental/physical health/insurance/community resources).
- Referrals made (e.g., mental health services, primary care physicians, dental providers, insurance, developmental services, other Public Health Nurse programs, and other community-based resource).

Learning objective #2 - Does increasing access to prevention and early intervention reduce long-term mental health costs? The following indicators will be measured:

- The Family Strengthening Protective Factors Survey will be used to assess an adult's resilience by measuring isolation, education, developmental understanding, and support. It also will measure the impact of services on wellness for children birth through five, and their parents/guardians.
- The project also will investigate, to the extent possible, if there is a reduction in the prolonged suffering that may result from untreated mental illness by measuring reduced symptoms and/or improved mental, emotional, and relational functioning, as reported on client satisfaction or other surveys.

Learning objective #3 - Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?

- Tracking referrals received and client contacts.
- Linkage by type and source (e.g., mental health/dental/physical health).
- Referrals made (e.g., mental health services, primary care physicians, dental providers, etc.).

Learning objective #4 - Does case management by a Public Health Nurse increase client screening and treatment for mental health services?

- Public Health Nurses administer a variety of screening tools, including screening for postpartum depression and ACEs.

Learning objective #5 - Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?

- Tracking of referrals received and client contacts, including data gathering relative to clients being unserved or underserved.

Learning objective #6 – Can Community Hubs be sustained through local planning and leveraging of resources?

- One of the positive outcomes of this identified challenge is that the partnering agencies have been creative with looking at how funding between their programs and potential funding from other sources can be coordinated to maximize benefits to the community and avoid duplication of efforts.
- The funding partners to this program are continually examining how to sustain this project in the long-term. At the conclusion of the Innovation funding period, MHSA would consider transferring funding to the Prevention and Early Intervention component.

Additional data points may be collected based upon general number of contacts made and demographics, as well as future identified data points that would aid in project evaluation (i.e., future stakeholder input may identify additional data points that would aid in evaluation).

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The County of El Dorado will contract with El Dorado County Office of Education for the provision of the Family Engagement Specialist services. The remainder of the services are provided by County employees or employees of partner funding sources.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Throughout El Dorado's MHSA Community Program Planning Process (CPPP), the general public and stakeholders were invited to provide input in or host MHSA planning opportunities and to provide comments to contribute to the development of the MHSA Annual Update and the Innovation plans. Community meetings were held county-wide, both during the day and at night. A total of 121 individuals attended the meetings. MHSA also participated in the County of El Dorado's Health and Human Services Agency's Community Open Houses. Approximately 250 community members stopped by the MHSA booth. MHSA staff was available to provide information and answer questions regarding MHSA programs and Innovation proposals.

Additionally, MHSA distributed surveys, soliciting input on the FY 2019/20 Annual Update and this Innovation modification. MHSA received a total of 302 surveys (185 online via SurveyMonkey® and 117 paper surveys, which included 29 Spanish responses).

The County's Behavioral Health Commission invited Community Hubs leadership to present an overview and progress to date of the project at their April, 2018 and April 2019 meetings. The community also was in attendance at that meeting and both the Commission and the public provided additional input.

Finally, community members, Hub partner agencies and MHSA staff participated in a "Strengths, Weaknesses, Opportunities, and Threats" (SWOT) workshop/assessment of the Community Hubs. The SWOT workshop was facilitated by trained facilitators who are external to the Community Hubs projects.

Through the Community Program Planning Process, the Behavioral Health Commission meetings, and the SWOT assessment, it was discovered that the Community Hubs are highly regarded as a valuable resource and asset to El Dorado County. Modification and continuation of the Community Hubs project is supported by the community and

stakeholders. In addition to feedback received at Community Program Planning Process meetings, MHSA staff received over two dozen letters of support for the Community Hubs. While community support for the Hubs is present, the Hub partners continue to work on the back-end of the program to determine the benefit, viability, and sustainability of the Hubs program.

The proposed modification to this Innovation program was published for Public Comment on April 19, 2019. Public Comment ended May 19, 2019 and the Public Hearing before the El Dorado County Behavioral Health Commission was held on May 22, 2019. The County's Behavioral Health Commission continued the meeting to June 12, 2019. At the June 12, 2019 meeting, the Behavioral Health Commission recommended approval of the MHSA Annual Update, including the Hub modification; however the Commission did express their desire for more data for program evaluation.

The County of El Dorado Board of Supervisors approved the proposed Innovation modification on June 25, 2019.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

This project will meet the following General Standards:

A) Community Collaboration through multiple partners working together in the Community Hubs, providing referral and linkage to services as necessary.

   Staff members working within the Hubs model provide referrals and linkage to services as necessary based on individual needs. Please see the list of referral types under "Proposed Project" above.

B) Cultural Competence – all services are provided in a culturally and linguistically manner.

   In areas of the County where threshold languages are English and Spanish, the Community Hubs ensure that bilingual staff is available.

C) Client-Driven – all services are client-driven.

   Individuals who visit the Community Hubs can access multiple programs and they can engage in the programs they are most interested in.

D) Family-Driven – the Community Hubs offer services for individuals and families.

Families can engage in programs they are most interested in. Services may be provided to the entire family, or specific members of the family, as may be appropriate. For example, the Hubs teams have noticed an increase in families where the grandparents are raising their grandchildren. The needs of the grandparents as "parents" may be addressed separately than the needs of the grandchildren, but the benefit of these services is for the family.

E) Wellness, Recovery, and Resilience-Focused –

The First 5 survey focuses on resiliency. In FY 2017/18, survey results yielded 25% of the Community Hub participants experienced growth in protective factors, including gains relative to social connections, parental resilience, children social and emotional security, and knowledge of parenting and child development.

F) Integrated Service Experience for Clients and Families –

The Community Hubs are comprised of a collaboration of agencies. By virtue of this design, clients and families are able to engage in services provided my multiple community partners, including First 5, Education, Public Health, Behavioral Health, and Libraries, who through referrals and linkage connect participants with any number of community or governmental-based services, such as primary care, dental, Social Services, Veterans services, and any number of other organizations to address the individual needs of the participants.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

The Learning Objectives and Outcomes are written with consideration of being culturally competent, and reflective of stakeholder participation. Stakeholders have expressed their desire for hard numbers related to the services (e.g., number and type of referrals, number of linkages). This input is reflected in the evaluation process developed.

Services are provided without regard to gender identity, race, ethnicity, sexual orientation, and/or language used to communicate; and services will be provided in a culturally competent manner, appropriate to the needs of each individual client.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

Based upon the outcomes of the "Learning Objectives," the County will decide whether to continue with the entirety of this Innovation project or whether to only maintain portions of the project funded through the MHSA components of Community Services and Supports and/or Prevention and Early Intervention at a funding level commensurate with the benefit found. It is anticipated that most of the participants will benefit from some level of service, whether it is prevention and early intervention mental health services, or access and linkage to Specialty Mental Health Services providers.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

Historically, throughout the MHSA CPPP, El Dorado County MHSA reviews and explains the various existing approved MHSA projects to stakeholders and community members. This provides MHSA with an opportunity to share developments and discoveries acquired in the implementation of projects, as well as to seek feedback from the community.

In development of this Innovation Project modification, many stakeholders demonstrated significant knowledge of the project and they provided input on the learning objectives. Additional data and interim outcomes will be communicated at the CPPP meetings and they will be discussed in the Fiscal Year 2019/20 Annual Update. Presentations have been made to the Behavioral Health Commission in FY 17/18 and FY 18/19 with updates on how the project implementation is progressing and interim preliminary evaluation information, such as the number of contacts made and the number of referrals made.

Additionally, MHSA also will keep stakeholders informed via the County of El Dorado's Health and Human Services Agency Facebook pages and the County's Behavioral Health and MHSA internet webpages.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

1. Community Hubs
2. Mental Health screening in libraries
3. Community Health Advocates in libraries
4. Adverse Childhood Experience Study and Community Hubs
5. Mental health screening in rural communities

TIMELINE

A) Specify the expected start date and end date of your INN Project

This Innovation project was first approved by the MHSOAC on August 15, 2016 and implementation (start date) of the project began on September 19, 2016 with limited direct services beginning on May 1, 2017. This expansion request includes extending the end date to June 30, 2021, largely due to initial challenges in staffing, delay in full implementation, and ongoing evaluation challenges.

B) Specify the total timeframe (duration) of the INN Project

The total timeframe for this Innovation project is slightly over four years, 9 months, based on the date of implementation.

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

The anticipated timeline, inclusive of this modification, with quarters based on a starting quarter of July – September, to coincide with the County's Fiscal Year:

Timeframe	Key Activity/Milestones/Deliverables
Quarter 1 (July – Sept 2017)	• Continue operating the Community Hubs • Preliminary evaluation of the project and identification of barriers and challenges
Quarter 2 (Oct – Dec 2017)	• Continue operating the Community Hubs • Community Program Planning Process • Discussions regarding the need for the expanded Innovation Program
Quarter 3 (Jan – Mar 2018)	• Continue operating the Community Hubs • Publication of the Draft Innovation Program as part of the FY 2018-19 MHSA Annual Update for a 30-day comment period

Timeframe	Key Activity/Milestones/Deliverables
Quarter 4 (April – June 2018)	• Continue operating the Community Hubs • Public Hearing on the FY 2018-19 MHSA Annual Update and Innovation project • MHSOAC advised the County that the County was required to utilize the newly released Innovation Template and could not proceed for MHSOAC approval with only the information presented in the FY 2018-19 MHSA Annual Update
Quarter 1 (July – Sept 2018)	• Continue operating the Community Hubs • Board of Supervisors adoption of the FY 2018-19 MHSA Annual Update, inclusive of this Innovation Program • Research and drafting of MHSOAC Innovation template • Community Program Planning Process
Quarter 2 (Oct – Dec 2018)	• Continue operating the Community Hubs • Research and drafting of MHSOAC Innovation template • Community Program Planning Process
Quarter 3 (Jan – Mar 2019)	• Continue operating the Community Hubs • Community Program Planning Process • Drafting of the FY 2019-20 MHSA Annual Update
Quarter 4 (April – June 2019)	• Continue operating the Community Hubs • Publication of the Draft Innovation Program as part of the FY 2019-20 MHSA Annual Update for a 30-day comment period. • Public Hearing on the FY 2019-20 MHSA Annual Update and Innovation project • Board of Supervisors adoption of the FY 2019-20 MHSA Annual Update, inclusive of this Innovation Program
Quarter 1 (July – Sept 2019)	• If necessary, recruit/interview/hire new staff and purchase equipment • Continue operating the Community Hubs •

Timeframe	Key Activity/Milestones/Deliverables
Quarter 2 (Oct – Dec 2019) Quarter 3 (Jan – Mar 2020) Quarter 4 (April – June 2020) Quarter 1 (July – Sept 2020) Quarter 2 (Oct 2020 – Dec 2020) Quarter 3 (Jan – Mar 2021) Quarter 4 (April – June 2021)	• Continue operating the Community Hubs • Quarter 2 (Oct – Dec. 2019) or early Quarter 3 (Jan – Mar 2020) - Present the Community Hubs Innovation Extension to the MHSOAC for review and approval • Quarter 2 from Oct. – Dec 2019 - Evaluate continuing the Community Hubs program through the Community Program Planning Process for the 3-Year MHSA Program and Expenditure Plan covering Fiscal Years 2020 - 2023, including evaluating transferring the project to PEI after conclusion of the Innovation funding period • Continue operating the Community Hubs, and if appropriate, transfer to PEI at the conclusion of the Innovation funding period.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and

indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Please see budget from initial approved MHSA Innovation Project.

Additionally, this project is appropriate for the Innovation component because it promotes interagency collaboration related to mental health services in a promising and community-driven. This project received support from many agencies in El Dorado County. The project includes not only Innovation funds, but other funds from HHSA Public Health MCAH funds and First 5 Commission funds, along with in-kind support from HHSA Public Health and the First 5 Commission. The project includes funding for one additional year of operations due to the staffing challenges and delay in implementation of the project, as well as additional supports to ensure that the learning objectives of this project may be evaluated.

Expenditures

Due to a change in the MHSOAC's budget structure on the template from 2016 to 2019, the original Innovation project budget does not directly translate into the new format. Expenditures that were formerly reported as "Administration" are now split between Indirect Costs and Administration and therefore the cost of Administration appears to have significantly decreased while Personnel costs appear to have significantly increased.

Innovation Funds, including AB114 Reversion and MHSA Innovation Funds

AB 114 Reversion funds for Innovation will be utilized for this project as long as those funds are available. When there are no AB 114 Reversion funds for Innovation available, then regular MHSA Innovation funds will be utilized.

Initial <u>Approved</u> Budget (Innovation Funds Only) (Approved August 2016):

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Personnel	$279,176	$293,135	$307,792	$323,182	--	$1,203,285
Operating Costs	$54,700	$57,435	$60,305	$63,325	--	$235,765
Non-Recurring Costs	--	--	--	--	--	--
Contracts	--	--	--	--	--	--
Evaluation	--	--	--	--	--	--
Administration	$306,481	$321,805	$337,895	$354,790	--	$1,320,971
Total	**$640,357**	**$672,375**	**$705,992**	**$741,297**	--	**$2,760,021**

Given the shift in the Innovation template as to where costs are recorded, here is the initial approved budget in the updated format starting with the current fiscal year (FY 19/20):

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Personnel	$279,176	$293,135	$307,792	$676,272	--	$1,556,375
Operating Costs	$54,700	$57,435	$60,305	$63,325	--	$235,765
Non-Recurring Costs	--	--	--	--	--	$0
Contracts	--	--	--	--	--	$0
Evaluation	--	--	--	--	--	$0
Administration	$306,481	$321,805	$337,895	$1,700	--	$967,881
Total	**$640,357**	**$672,375**	**$705,992**	**$741,297**	--	$2,760,021

The MHSOAC-approved project also included leveraged funds and in-kind contributions:

Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Leveraged Funds and In-Kind	*$920,883*	*$1,020,126*	*$1,058,012*	*$1,097,911*	--	*$4,096,932*
Total Project Budget	***$1,561,240***	***$1,692,501***	***$1,764,004***	***$1,839,208***	**--**	***$6,856,953***

<u>Modification</u> Budget (Innovation Funds Only):

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Personnel	--	--	--	$241,569	$993,313	$1,234,882
Operating Costs	--	--	--	$49,686	$122,303	$171,989
Non-Recurring Costs	--	--	--	$120,000	--	$120,000
Contracts	--	--	--	$289,148	$321,885	$611,033
Evaluation	--	--	--	$8,300	$10,000	$18,300
Administration	--	--	--	--	$2,500	$2,500
Total	--	--	--	$708,703	$1,450,001	$2,158,704

This modification includes items to address the above-referenced challenges, including:

- Increased personnel:
  - 0.80 FTE Supervising Public Health Nurse
  - 1.00 FTE Sr. Analyst (equivalent or lower classification)
  - 2.50 FTE Family Engagement Staff (contracted)
  - 0.10 FTE Supervising Quality Improvement and Family Support Coordinator
- Technology Upgrades
- Revised project end date to 6/30/2021 from 9/18/2020.

Total <u>Approved and Modification</u> Budget (Innovation Funds Only):

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Personnel	$279,176	$293,135	$307,792	$917,841	$993,313	$2,791,257
Operating Costs	$54,700	$57,435	$60,305	$113,011	$122,303	$407,754
Non-Recurring Costs	--	--	--	$120,000	$0	$120,000
Contracts	--	--	--	$289,148	$321,885	$611,033
Evaluation	--	--	--	$8,300	$10,000	$18,300
Administration	$306,481	$321,805	$337,895	$1,700	$2,500	$970,381
Total	**$640,357**	**$672,375**	**$705,992**	$1,450,000	$1,450,001	$4,918,725

While this appears to be a significant increase in Personnel and a significant decrease in administration starting in FY 19/20 as compared to previous fiscal years, that is a result of changes to the MHSOAC's template in terms of where costs are recorded. It is also important to note that Personnel, Operating Costs, and Contracts all have a built in annual increase to account for potential increases to the underlying costs (e.g., salary increases, increase in the cost of benefits, rent increases).

Due to the implementation of this modification in the latter part of FY 19/20, unused FY 19/20 funds may roll over for use in the same cost category in FY 20/21, in addition to the funds specifically allocated to those each cost category for FY 20/21.

Cost Category Detail

- ***Personnel***
  Personnel funded by MHSA Innovation are:

Position	2016 Approved Project	2019 Modification	Total
Public Health Nurses	2.5 FTE	--	2.5 FTE
Supervising Public Health Nurse	0.2 FTE	+0.8 FTE	1.0 FTE
Sr. Analyst (equivalent or lower classification)	--	+1.0 FTE	1.0 FTE
Family Engagement Staff (contracted)	--	+2.5 FTE	2.5 FTE
Supervising Quality Improvement and Family Support Coordinator (contracted)	--	+0.1 FTE	0.1 FTE

  Indirect costs are allocated to programs based upon project salaries and include:
  - County A-87 Costs;
  - Facility Maintenance;
  - Administrative and Fiscal Costs;
  - Insurance;

- Central Government Costs (Mail and Stores).

- ***Operating***
  Operating costs allocated to this program and relate to cost of doing business expenses that can be directly attributed to this project or indirect costs that can be attributed as operating costs for this project, including but not limited to items such as rent, communications, network fees, travel expenses, etc.

- ***Non-Recurring Costs***
  Non-recurring costs include technology upgrades ($100,000), and laptops, docking stations, wireless cards, other peripheral devices and technology-related needs ($20,000). As discussed above, these items will address data gathering challenges.

- ***Contracts***
  Family Engagement Staff and the Supervising Quality Improvement and Family Support Coordinator will be contracted to El Dorado County Office of Education (EDCOE). EDCOE is already providing 2.5 FTE Family Engagement Staff, but due to funding restrictions those staff can only work with individuals of a specific age. Increasing their staff through MHSA funds allows them to work with more individuals.

- ***Evaluation and Administration***
  These costs are for County personnel to administer (contracting, invoice processing, etc.) and evaluate the program, and are inclusive of indirect costs in the sum of approximately $3,900 for FY 19/20 and $4,875 for FY 20/21. County personnel from the MHSA Team will be performing these tasks. FTEs are anticipated to be 0.25 FTE Sr. Analyst, 0.2 Administrative Technician, and 0.05 FTE Program Manager, or variation of the total FTEs using the same classifications dependent upon tasks to be accomplished.

Actual Expenditures:

Actual expenditures have fallen short of the initial approved budget in the first two years of operations by nearly $750,000, which is largely due to implementation delays and low initial staffing levels.

Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Budget	$640,357	$672,375	$705,992	$741,297	--	$2,760,021
Actual Expenditures per ARER[8]	$134,501	$428,353	TBD*	TBD	TBD	TBD
Underspent by	$505,856	$244,022	TBD*	TBD	TBD	TBD

* Actual expenditures for FY 18-19 are not yet available, but it is anticipated that the annual expenditures will once again be below the budgeted amount.

[8] Annual Revenue and Expenditure Report (ARER)

Funding by Source and Fiscal Year

This Innovation project is a partnership between several entities, including Behavioral Health (MHSA), Public Health, First 5 El Dorado, and El Dorado County Libraries. While the budgets above reflect only MHSA Innovation funding, the following charts reflect the various funding sources for this partnership project, with the exception of the Libraries.

The Libraries are providing office space throughout the week, as needed, and space for health information to be displayed. It is difficult to assess the actual leveraged or in-kind contributions of the Libraries and their staff, but they are an integral partner in this program even though their specific fiscal contribution is not identified.

Initial Funding Sources (Approved August 2016):

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Innovation Funds	$640,357	$672,375	$705,992	$741,297	--	$2,760,021
Public Health MCAH Funds	$660,417	$693,438	$728,110	$764,516	--	$2,846,481
Public Health In-Kind	$46,289	$48,603	$51,034	$53,585	--	$199,511
First 5 El Dorado Funds	$187,500	$250,000	$250,000	$250,000	--	$937,500
First 5 El Dorado - In-Kind	$26,677	$28,085	$28,868	$29,810	--	$113,440
Total	$1,561,240	$1,692,501	$1,764,004	$1,839,208	--	$6,856,953

EDCOE has been an important partner since the start of this project. However, since the original program approval did not include EDCOE's contribution, their financial contribution is listed here as starting in FY 19/20:

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
El Dorado County Office of Education	*Not included in original budget*	*Not included in original budget*	*Not included in original budget*	$160,808	--	$160,808

Total Initial Funding including EDCOE:

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Total	$1,561,240	$1,692,501	$1,764,004	$2,000,016	--	$7,017,761

Proposed Modification Funding Sources:

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Innovation Funds	--	--	--	$708,703	$1,450,001	$2,158,704
Public Health MCAH Funds	--	--	--	-	$802,742	$802,742
Public Health In-Kind	--	--	--	-	$56,264	$56,264
First 5 El Dorado Funds	--	--	--	-	$250,000	$250,000
First 5 El Dorado - In-Kind	--	--	--	-	$30,704	$30,704
El Dorado County Office of Education*	--	--	--	-	$160,808	$160,808
Total	--	--	--	$708,703	$2,589,711	$3,298,414

The above amounts for the Modification and EDCOE's contribution are estimates that may vary dependent upon available grant funding or other variables (such as actual staffing levels, project needs, grant renewals, etc.).

Total <u>Initial and Proposed Modification</u> Funding Sources (including EDCOE):

Cost Category	FY 16-17	FY 17-18	FY 18-19	FY 19/20	FY 20/21	TOTAL
Innovation Funds	$640,357	$672,375	$705,992	$1,450,000	$1,450,001	$4,918,725
Public Health MCAH Funds	$660,417	$693,438	$728,110	$764,516	$802,742	$3,649,223
Public Health In-Kind	$46,289	$48,603	$51,034	$53,585	$56,264	$255,775
First 5 El Dorado Funds	$187,500	$250,000	$250,000	$250,000	$250,000	$1,187,500
First 5 El Dorado - In-Kind	$26,677	$28,085	$28,868	$29,810	$30,704	$144,144
El Dorado County Office of Education*	*Not included in original budget*	*Not included in original budget*	*Not included in original budget*	$160,808	$160,808	$321,616
Total	$1,561,240	$1,692,501	$1,764,004	$2,708,719	$2,589,711	$10,316,175

* Funding that originates from First 5 El Dorado to El Dorado County Office of Education for the current services of Family Engagement Specialists remains budgeted under First 5 El Dorado. Funds from MHSA Innovation to El Dorado County Office of Education for an expansion of the Family Engagement Specialists is reflected under Innovation Funds. The El Dorado County Office of Education funding identified is from sources other than First 5 El Dorado or MHSA.

June 12, 2019

To: Behavioral Health Commission
From: Norma Santiago, Behavioral Health Commission, Member
RE: Community-Based Engagement and Support Services – Existing Project and Proposed Expansion

Since our meeting on May 22nd, I have compiled some points to help clarify my understanding as to the objections raised regarding the Community Hubs and their effectiveness as it relates to mental health.

Generally, there was agreement that the community hubs model is a good model; however, the main objection was that given the amount of money invested in this program, specifically with MHSA innovation dollars, there wasn't enough data to substantiate the investment. In other words, the community hub model appears not to work in the case of identifying and treating individuals in need of mental health services. This conclusion is based upon the low number of referrals to Behavioral Health in relation to the number of MHSA dollars invested.
With this in mind, I looked at the following documents to help me ascertain the effectiveness of this investment:

1) EDC Community Hub 1 – Linkage Process, DRAFT August 15 2017
2) Interagency referral form – specifically looking at the PHN Referral Criteria and what MHSA covers in that context. MHSA innovation dollars pay for the referral criteria listed under 'At-Risk Families' which include early indication of possible mental health concerns.
3) Intake check list – Here under the 'Public Health Nurse Referral' is a check box indicating "mental health concerns for a child, parent or family member".

From this, I was able to gain a further understanding of the primary objectives of the program:

1) How can the best connection be achieved between services and those needing these services.
2) Building strong relationships with families
3) Build upon existing services to maximize dollars

It is important to remember that this program is an intervention and prevention program and the structure of the Community Hubs has been recognized as being innovative.
Through the efforts of Family Engagement Specialists, Community Health Advocates, and Public Health Nurses, we can assist the communities find the help they need. However, when evaluating the limited data before us, it is difficult to assess the success of the program. For example, at the May 22nd meeting, Lynnanne reported the for the first three quarters of 2018/19 there were 2157 Client Contacts, 98 Mental Health referrals, and 31 Direct Services.

If one looks simply at the referrals, one could, understandably, draw the conclusion that we are not getting a significant return on these MHSA innovation dollars. However, I would argue that the Client Contacts which, in many instances, are handled by the Family Engagement Specialists (FES) provide an opportunity to connect community members to needed services including mental health. The FES is part of the first line of defense in preventing early indicators into morphing into more serious problems that can lead to the need for more costly services. This is the major objective of a prevention program. Unfortunately, there is no data available to ascertain the effectiveness of this component of the Community Hub. It is my understanding that as this innovation program continues, there will be ways to capture many data points to

better ascertain program success than just referrals. As this is a system change, there is no doubt that some tweaking is going to be needed as the program evolves.

After extensive review of the annual update, evaluation of the plan to extend capacity, and speaking with agencies that provide these important services, I, strongly, support the recommendations provided in annual update for this program and suggested funding. To that end, I am prepared to make a motion stating such at the appropriate time.

Respectfully submitted,

Norma Santiago

Shared Vision/Bringing the Library to You Grants

The 2019-20 California state budget contains $8 million for the State Library to provide grants to local public library jurisdictions to implement early learning and after school programs, and to support mobile library solutions. These new grant programs, which are currently under development, will increase Californians' access to health, educational, workforce and other services, while also increasing the mobility and accessibility of public libraries.

Shared Vision Community Partnership Grants for Early Learning and Out-of-School Time Programs - $5 Million

- **Early Learning** – Early Learning grants will aim to connect children, youth, families and caregivers with the services they need to thrive. As trusted, stigma-free community hubs, libraries offer a unique setting to strengthen at-risk families, promote wellness and deliver a range of important early learning opportunities. Grants will help libraries create and strengthen partnerships with other critical community services and institutions, from local elementary schools, to health clinics, to First 5 organizations, to apprenticeship programs, to mental health services agencies to better deliver these services. By further integrating the work of libraries and other community service providers, Californians will have easier access to the resources they need where and when they need them.
- **Out-of-School Time** – A California child spends six hours a day in a classroom and 10 waking hours outside of one. The average school year lasts 180 days. These grants will focus on supporting and expanding the critical role libraries play for children and teens during the 60 percent of their lives they aren't in school. Libraries provide free and welcoming spaces, STEAM programming, health and wellness activities and help develop leadership skills and social-emotional and workforce readiness in youths. Like the Early Learning grants, the involvement of other community partners will broaden the impact of the services provided.

Bringing the Library to You: Mobile Library Solutions Grants - $3 Million

- Bringing the Library to You grants will help libraries implement new ways to bring literacy, technology and other services to those who face challenges visiting their local library. When Californians lack transportation, live far from their library, or work long hours, mobile library solutions make it possible to access library services and programs.

More information about these grants will be available soon! Three one-hour online meetings have been scheduled, one for each program area (see registration links below)

We invite you to join us, hear about what's being planned, and give your feedback and input.

- **Bringing the Library to You: Mobile Library Solutions Grants (July 25, 2019, archived version)**
- **Shared Vision: Early Learning Grants (July 30, 2019, archived version)**
- **Shared Vision: Out-of-School Time Grants (August 6, 2019, 11 AM)**

Questions? Contact:

- Mobile Libraries Solutions Grants: **Beverly Schwartzberg**
- Shared Vision Early Learning Grants: **Carolyn Brooks**
- Shared Vision Out-of-School Time Grants: **Natalie Cole**
- **Library Development Services**

Barton Health

2170 South Avenue
South Lake Tahoe
CA 96150

530.541.3420 TEL
bartonhealth.org

April 3, 2019

To whom it may concern,

The pediatricians of South Lake Tahoe would like to send our appreciation for the funds that have supported the additional resources to our community through the First 5 program. These programs have been essential to our pediatric patients and we have no other fail-safe to step into their place should this program not be renewed.

Besides the amazing resources for our families, it has provided a framework for our hospital and other local resources to collaborate, including El Dorado County Public Health Nursing. We have been able to establish lines of communication and pathways for referrals to these resources that otherwise would never have occurred.

Thank you for your continued support of the health of our children, which is the future of the health of our community.

With sincerity,

Matthew Wonnacott MD
Chief Medical Officer
Barton Health System

BAYSIDE
CHURCH OF PLACERVILLE

April 18, 2019

EDC Behavioral Health Commission

Greetings,

I am writing in support of funding for Community Hubs as part of the Mental Health Services Act Innovations Act. Community Hubs are a valuable resource to our county. They provide physical and mental health resources and services to at-risk families in our county. In the fiscal year 2017 – 2018 they served 1482 children and families and hope to serve more in the upcoming year.

As a pastor and chaplain I see families at some of their most difficult moments in life. Community Hubs are a valuable recourse offering services to families who may otherwise not have access to care. Early intervention is a small investment that pays large dividends by improving the quality of life for some of our most important residents, our children, and can decrease their needs for greater services later in childhood, by providing preventative services and education to parents early in their parenting experience.

I highly encourage you to consider and support this funding.

Sincerely,

Betsy Vanderpool

Betsy Vanderpool
Care & Connection Pastor

4602 Missouri Flat Road, Placerville, CA 95667 • 530-626-7288 • baysideplacerville.com

BUCKEYE UNION SCHOOL DISTRICT
5049 Robert J. Mathews Parkway
El Dorado Hills CA 95762

April 10, 2019

First Five, El Dorado County
2776 Ray Lawyer Drive
Placerville CA 95667

ATTN: Kathi Guerrero, Executive Director

To whom it may concern:

We are honored to write on behalf of our El Dorado County Community Hubs as part of the Mental Health Services Act and Innovations Grant as considered by the El Dorado County Behavioral Health Commission. We have heard that they are seeking additional funding through MHSA to augment their project and increase the Family Engagement staff as they are currently part-time. To do so will help them plan for sustainability.

Our professional interactions with the Community Hub nurses and their support staff come from direct contact as a district level nurse with Buckeye Union School District, serving the needs of over 4,700 children in our community. The Community HUB staff members serve to assist and support our role in public health at times when assistance has been required to help meet the needs of the children in our county. In fact during 2017-2018 they were able to reach 1,482 children in the county, but I am guessing that we can improve on this with additional support.

Our Community Hubs have a great deal of positive influence, and although restricted in hours, they always seem to make time for a student, parent, or other community member. If they say they will research an area of concern, they will certainly come back to us with timely answers. They are dedicated to connecting our children and their families with medical services. They have a genuine interest in bettering outcomes for our students and providing materials on prevention to stop a problem in its tracks. Being connected at the library, where public transportation makes it possible for many families to connect with the Community Hub staff make it much simpler for them to offer early screening and identification for areas of concern with regard to both mental and medical health outcomes alike.

We feel that our Community Hub staff members have the desire to find a better way to reach the members of our community who need assistance and intervention, even if the way in the past was considered satisfactory. This is really the essence of what we all need to harness in order to move into a brighter future. We would recommend your support for the Community Hubs without reservation. Please feel free to contact either of us should you have any questions.

Sincerely,
Tristan Kleinknight, RN MSN PHN & Sandy Chavez, RN MSNc PHN
Tristan Kleinknight, RN MSN PHN & Sandy Chavez, RN MSNc PHN

April 17, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2766 Ray Lawyer Drive
Placerville, CA 95667

Dear Commissioners,

The California State Library Early Learning with Families Initiative supports the innovative Community Hubs in El Dorado County where young families and their young children naturally gather. When looking to build Community Hubs, First 5 El Dorado built upon the strong foundation of the County Library System.

Libraries are safe, accessible, and stigma-free gathering place for families with young children. They provide needed infrastructure and are cost-effective with a countywide network already established in population centers. Community Hubs are a partnership that connect families with the supports they need to thrive because we know that hungry children can't learn, sick children can't grow, and toxic stress damages children and their families. The California State Library will continue to support the El Dorado County Community Hubs in their local libraries as they play a key role in reinventing service delivery and are used as essential model that is being replicated across the state.

In El Dorado County, one in four families with children under the age of five visit libraries making it the most accessible public service for children. Libraries offer services for all families and are not limited by eligibility requirements required by other agencies, for example, an entitlement or result from a negative experience such as involvement with child protective services. Libraries are essential partners for ensuring children are ready for school. The Community Hub services build upon resiliency and are free of cost are not provided through Plexiglas.

The goal of Community Hubs is to build family resiliency using the Family Strengthening Protective Factors. In 2017-18, a total of 4,678 (duplicated across Hub programs) individuals were provided with First 5 funded services, resulting in the following accomplishments:

- Families are using positive strategies to guide and teach their children. Seventy-eight percent (78%) of parents reported that they or another family member reads with their child each day.
- Children are receiving preventive health care. Eighty-nine percent (89%) of parents reported that their children birth through 5 had received timely well child visits.
- Children are being screened for developmental delays. A total of 612 children received either an ASQ or ASQ:SE developmental screening.

One in four families completing the First 5 Family Survey experienced growth in each of the Family Strengthening Protective Factors.

In supporting Community Hubs, the California State Library Early Learning with Families Initiative is confident they are addressing their goals of providing prevention and early intervention services to families and their children. In El Dorado County libraries have leveraged over a million dollars in the last decade to enhance base services and extend their reach in the community. They are a leader and exemplary model for delivering early learning services in the state.

Sincerely,

Carolyn Brooks

Carolyn Brooks
Library Programs Consultant
Early Learning with Families Initiative
California State Library

April 22, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear El Dorado County Behavioral Health Commission,

The El Dorado County Child Abuse Prevention Council strongly supports the continuation and expansion of the Community Hub Project that ensures children and families get connect to services throughout the county. This project is critical to ensure that the children and families of El Dorado County are healthy and thriving.

The Child Abuse Prevention Council serves children and families throughout the county as well as provides local leadership for prevention and education on abuse. We work closely with our county Health and Human Services Agency and understand the need for the resources that the Hub offers particularly to our most vulnerable families. Our fifteen-member council is a public private partnership whose membership is composed of early care community agencies, community members, faith based organizations, health and mental health services, parents and advocates, and law enforcement.

Our council is excited about the work the Hubs have already developed. The Hub staff support families gain access to essential mental health services in our county. These services are imperative to strengthening families and preventing child abuse. When a child and family are doing well and have access to supports and resources, they are significantly less likely to be in situations of abuse. By connecting families to services, the Community Hubs strengthen the entire family's health. For families who are isolated, the Hubs are an essential resource for health and mental health education and access. Health specialist at each Hub individually support families and provide continuity of care for those needing help.

Expanding the Community Hub Project will have a lifelong positive impact on the families of El Dorado County. Proactively investing in children and families ensures countywide improvement and strengthening. For these reasons, the El Dorado Child Abuse Prevention Council respectfully asks for your continued support and expansion of the Hubs.

Sincerely,

Commander Kim Nida, Chair
Placerville Police Department

Jenna Knight, Council Coordinator
El Dorado Early Care & Education Planning Council

Choices for Children

www.choices4children.org

Resource & Referral Program
Child Care Subsidy Program
Child Care Food Program
Training & Resource Development

April 17, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Behavioral Health Commission,

For the past three years Choices for Children has developed a successful partnership with the Community Hubs. Our relationship is based on the foundational goal of strengthening family's lives. Collaboration with the Community Hubs is essential to supporting families and building resilience. The Hubs refer families to Choices for Children to receive Child Care Referrals, information about Subsidized Childcare options, and Parent and Provider Education services. Choices for Children refers parents and providers to the Hubs for services related to early literacy, public health, Play & Learn Activities and Ages and Stages services. We value the continued collaboration and support from the Community Hubs during our Annual Kids' Expo and Day of the Young Child events.

Choices for Children looks forward to continuing our partnership with the Community Hubs Maternal Child Adolescent Health services. According to the El Dorado County Community Hubs Report, last year 1,482 families were reached through the Hubs. Prevention and early intervention and mental health access for pregnant women, families and children ages birth through 18 years is greatly needed. The HUBS provide an innovative approach to families receiving these vital services.

The result of Hubs services will be a greater number of our county's most vulnerable residents receiving high quality support, resources that improve their health, functioning and effectiveness later in life. I confidently recommend El Dorado County Hubs for the Mental Health Services Innovation Grant. I am certain that the Hubs will effectively meet and exceed all necessary MHSI funding requirements. Should you require any additional information please do not hesitate to contact me at 530-676-0707 or JLawrence@choicesforchildren.org.

In Partnership,

Jennifer Lawrence

Jennifer Lawrence
Director Resource & Referral, Choices for Children

South Lake Tahoe Office
1029 Takela Drive, Suite 1
South Lake Tahoe, CA 96150
Phone: 530-541-5848
Fax: 530-541-1376

Cameron Park Office
3161 Cameron Park Drive, Suite 101
Cameron Park, CA 95682
Phone: 530-676-0707
Fax: 530-676-8416

Markleeville Office
100 Foothill Rd., D-6, P.O. Box 215
Markleville, CA 96120
Phone: 530-694-2129
Fax: 530-694-1889

Children will be Healthy and Ready for School by Age 5

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

April 18, 2019

Dear Commissioners of the El Dorado County Behavioral Health Commission:

I am writing in support of Community Hubs as part of the Mental Health Services Act Innovations Grant under your consideration. As the Chair of Divide Ready by 5, (a grassroots community group that works to provide connections to services and information to families regarding school readiness, health, child development, literacy and parenting), I have worked directly with the Hub 4 team from the beginning. The Hub 4 team has become integral into all that we do as an organization on the Divide.

Divide Ready by 5 has been a presence in the community for over 10 years, and the Hub 4 team worked with us to quickly develop a strong foothold in the community. Divide Ready by 5 was welcomed by the Hub team as a community resource and we welcomed the Hub team! We gathered materials to help create a friendly space for families to meet with Hub team personnel at the Georgetown Branch library, and we have seen the library grow as the go-to place for community resources. We regularly refer families to the Hub 4 team for Storytime, health insurance, dental services, counseling services, health issues, child development and parenting help. The Hub 4 team has made a deep impact on our mission and has made it possible for us to connect more families to the services they need. We work hard to promote every Hub activity, group, support or class, as we know that this is how we can best serve our families.

We have partnered with the Hub team at all local events (where we have an active, child and family-centered activity booth) and now the Hub 4 team has booths at community events and engages in outreach to those hard to reach families. Hub 4 rapidly worked with us to connect to our social media and website – sending us information to post--and they continue to come to our monthly meetings to ensure strong community connection. Because Divide Ready by 5 has also worked closely with the school district, we worked with the Hub to build strong ties so the district staff would also refer families to the Hub. District staff know now that they have help through the Hub in supporting families in need. The Hub team comes to the school district Family and Student Services team meeting, allowing coordination between the school district and Hub in terms of services, events, meeting the needs for our community. The Hub team also works with us and the school district as a part of our Kindergarten Round-up; here the Hub 4 team can promote Hub services and reach many new families, as well as discuss literacy, health, child development and parenting issues and having each child screened by the Family Engagement Specialist with the Ages and Stages Social Emotional Questionnaire.

Community Hub 4 is a fundamental part of all the work that Divide Ready by 5 advocates. We strongly support the Community Hub project and hope it will be considered as a must by our county.

Sincerely,

Monica C. Woodall

Monica C. Woodall
Chair, Divide Ready by 5

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

April 7, 2018

Dear Commissioners of the El Dorado County Behavioral Health Commission:

I am writing in support of Community Hubs as part of the Mental Health Services Act Innovations Grant under your consideration. My role as a Board member of Georgetown Divide Ready By 21 has afforded me the chance to see our new Hub 4 in action. Georgetown Divide Ready By 21 acts as the non-profit umbrella organization for many groups, including those that work directly with Community Hubs personnel. Two of those groups are most active in coordinating with Hub 4 – Divide Ready By 5 and Drug Free Divide. We also work closely with our school district - Black Oak Mine Unified--to make sure they have current Hub information regarding services.

Even though the Community Hubs have only been in place for a short time, we have seen concrete work that has greatly improved the lives of some of our most needy families. Divide Ready by 5 connects local families in need of support with services. They have created a network through social media and community events and are known as a community resource for information for families in need. They meet monthly with the Hub 4 team to coordinate events and work together to continue to do outreach with hard to reach families. Divide Ready by 5 has helped Hub 4 create a welcoming space in their home of the Eldorado County Library (Georgetown Branch) and has facilitated connections for the team with our local preschools and the school district in addition to helping the team with all local events. Drug Free Divide includes the Hub team as part of their monthly meetings and helps Hub 4 connect with local junior and senior high school students and their families.

With this help, the Hub 4 team is now known as the premier resource for people who need health, mental health, intervention and parenting support, classes, and information. Divide Ready by 5 and Drug Free Divide have worked with the Hub team to make sure that our school district counselors, administrators, as well as teachers have information regarding Hub services. Divide Ready by 5 and the school district work closely with the Hub team to make sure families in need are connected to and receive services from the Dental Van each fall and spring. The Hub team is also a part of the school district intake process known as Kindergarten Round-up for all new Kindergarten enrollees in the school district. The Hub 4 Family Engagement Specialist meets with each family to take the Ages and Stages Social Emotional Developmental Screen and discuss each assessment with the family. Each family meets with the Hub 4 Community Health Advocate to assess health, dental and mental health needs and get connected to services.

Georgetown Divide Ready by 21 regards Hub 4 now as an integral part of our community services. They support our mission that all youth are "thriving and ready by 21."

Sincerely,

Drew Woodall, Georgetown Divide Ready By 21 Board member

April 22, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear El Dorado County Behavioral Health Commission,

The El Dorado County Early Care and Education Planning Council strongly supports the continuation and expansion of the Community Hub Project that ensures children and families get connect to services throughout the county. This project is critical to ensure that the children and families of El Dorado County are healthy and thriving.

The El Dorado Early Care and Education Planning Council serves the children, families, and early education programs in the county as well as provides local leadership for the planning and development of quality, accessible, affordable early care and education programs for children and families in El Dorado County. Our fifteen-member council is a public private partnership whose membership is composed of early care providers, parents, business, community agencies and government services.

The family engagement specialists at each of the Hubs successfully connect with families with young children to essential services in the community—mental health, oral health, insurance, literacy specialists, early interventionist, behavioral therapist. By connecting families to services, the Community Hubs strengthen the entire family's health. Additionally, the family engagement specialists lead playgroups for parents to learn about how their child develops and connect to one another. Through intentional curriculum and community, parents and caregivers build resiliency.

Expanding the Community Hub Project will have a lifelong positive impact on the families of El Dorado County. Proactively investing in children and families ensures countywide improvement and strengthening. For these reasons, the El Dorado Local Planning Council respectfully asks for your continued support and expansion of the Hubs.

Sincerely,

Jenna Knight, Council Coordinator

El Dorado Early Care and Education Planning Council

El Dorado County Office of Education
Child Development Programs and Services
6767 Green Valley Road
Placerville, CA 95667

April 16, 2019

Attn: Behavioral Health Commission,

This letter is in support of the El Dorado County Community Hubs and the incredible work that they do for the families in children in our community. As Coordinator of Quality Improvement and Family Support for Together We Grow at the El Dorado County Office of Education, I support with the coordination for the Family Engagement Team and their partnership within the Community Hubs. I speak with the Family Engagement Specialists daily about their efforts and the families they connect with. I am constantly moved by the collaboration at the Community Hubs and their aspirations to provide support for services to all families in need.

When thinking about the individuals we have supported in the Community Hubs, there is one particular story that I feel shows the direct impact of the innovation of our services in connecting families and children to mental health services. This fall, our Family Engagement Specialist, Jesus Cordova, received a call from a child care provider in Hub 3 (Placerville area). The provider expressed concerns about a child's aggressive behavior in the classroom and shared with Jesus that she was considering expelling the child from their center. She reached out to Jesus for ideas of how to support the child, as she had utilized all of her strategies and was unable to provide the child's mother with resources. Jesus met with the child's mother, developed a relationship with the family, learned about several challenges the they were facing, and supported the mother with completing a developmental screening for her child. He then simultaneously referred the family to the Community Hub Public Health partner for case management and New Morning for Parent Child Interaction Therapy (PCIT). The family not only engaged in both services, but the mother and child continued to come to Community Hub programs, such as story times and evening events at the library. All partners in Hub 3 interacted with this family and collaborated in an effort to provide high quality resources. This is one example of many stories we hear from the Community Hubs every day in our county.

As your commission reviews additional letters, please consider additional funds from the Behavioral Health Commission to be allocated towards the El Dorado County Community Hubs. Our teams are passionate about providing innovative services to all individuals in need in El Dorado County.

Sincerely,

Elizabeth Meyer, MS
Coordinator- Quality Improvement and Family Support
El Dorado County Office of Education

El Dorado County Growers Alliance

April 15, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Subject: Support For First 5 Community Hubs Through Mental Health Services Act Innovations Grant

To Whom It May Concern:

Community Hubs are more than an innovation. They are a revolution. From our point of view, preventing developmental problems is as great a community revolution as are the changes brought by new communications technology. It is within the community's power to reduce life-time problems such as substance abuse and mental health issues.

Our group seeks to promote the use of hubs as a part of a healthier community. It is essential for the El Dorado County community to support programs that foster healthy development of young people.

Please support the First 5 El Dorado County Community Hubs program with Mental Health Services Act funding.

Thank you for your attention to this matter.

R A Miller

Rod Miller
Legislative Director

530-503-9078
685 Placerville Dr., Suite 1024
Placerville, CA 95667

Infant Parent Center

April 19th, 2019

RE: El Dorado County Behavioral Health Commission

Dear Commission,

The Infant Parent Center is writing a letter in support of the El Dorado Community Hubs. Prevention and early intervention services are vital for our community. The Community Hubs have implemented a culturally diverse staff which allows for greater opportunity for linkage and connection to community providers. Greater cultural diversity in this community allows families to be seen and increases trust. It also encourages families to seek out services within the community. The collaborative approach with Public Health nurses is a wonderful opportunity for expectant families to access health care needs and screenings. Being a parent can be very stressful at times so a place where parents can gather for play groups, create connections, ask developmental questions and normalize parenting experiences is so incredibly helpful.
Any resource that has the potential to remove barriers for families, increase healthy connections, build resilience and decrease any potential toxic stress is a sure path to emotional wellbeing for families and children.

Kind Regards,

Alison Gardey & Jen Kalsbeek
Co-Founders

EL DORADO COUNTY Library

Jeanne Amos
Library Director

On behalf of the El Dorado County Library I would like to extend our support for the Mental Health Services Act Plan. We proudly partner with the Health and Human Services Agency, the El Dorado County Office of Education and First 5 El Dorado in offering services through the Community Hub model as part of the Innovation Project.

Five supervisorial districts are represented by a Community Hub in libraries located in El Dorado Hills, Cameron Park, Placerville, Georgetown, and South Lake Tahoe. Each site has a dedicated space for promoting and delivering Hub services.

We support the Five Protective Factors by:

- Providing a fun safe place where parents can make social connections during programs and in our play areas.
- Being a trusted resource for parents and encouraging active skill-building and building parental resilience.
- Sharing child development tips at every early literacy storytime and having Ages & Stages Questionnaire kits available for check out increases parenting and child development knowledge.
- Promoting Hub services provides a foundation for concrete support in times of need.
- Empowering parents to develop strategies using the social and emotional competence curriculum we have used across programs.

Hub partners regularly attend programs to share their expertise and establish relationships that open up opportunities to intervene early to address concerns or issues that all families may face.

Outside of the sites, Hub services extend beyond our walls. Raising Readers programs are delivered at school sites with a Family Engagement Specialist and an Early Childhood Literacy Specialist who provide child development and early literacy education with resources and incentives.

Our strength is our ability to attract a wide range of families to programming and then to share a wider array of supports. All library staff continue to expand their skills and knowledge. The Library has scheduled a professional development day to help staff become more competent at in serving those with mental health issues and to create an atmosphere of kindness and compassion for all library users.

Thank you for your support of the Community Hub model which provides vital support for our families and our community.

Sincerely,

Jeanne Amos

Jeanne Amos
Director of Library Services

345 Fair Lane
Placerville, CA 95667
Phone (530) 621-5540
FAX: (530) 622-3911
www.eldoradolibrary.org

Hub Story

The creation of Hub 4 at the Georgetown Library has had a significant impact on the Divide community. Hub 4 is able to offer resources formerly unavailable in the area. Library patrons who ask about health services, food programs or other social services are introduced to a Community Health Advocate who can assess their needs and guide them through the process of obtaining services. Communication about the Hubs has spread quickly, often through word of mouth, and community members know they can visit the library for multiple needs. Children have received dental care for the first time because they signed up for the Dental Van at Storytime, families now have access to health insurance and children are able to enter kindergarten on time because Hub 4 guided the family through vaccinations, dental appointments and Kindergarten registration.

A grandfather who has custody of his 4 year old grandson was feeling lost and overwhelmed. He brought him to the library for Storytime. After the program he connected with the Community Health Advocate who helped him through the process of signing his grandson up for health insurance, bringing his vaccinations up to date, and seeing a dentist. Through Storytime at Hub 4, he learned parenting techniques and tips from the Family Engagement Specialist and made social connections with other families. He and his grandson began attending the local co-op preschool. When a new set of grandparents caring for their grandchildren began coming to Storytime, he shared his experience with them and introduced them to the Hub team, The grandfather acknowledges that having a social network, learning about child development and knowing how to seek assistance when needed has given him the confidence and skills to raise his grandson.

345 Fair Lane
Placerville, CA 95667
Phone (530) 621-5540
FAX: (530) 622-3911
www.eldoradolibrary.org

Behavioral Health Network
South Lake Tahoe

4/20/2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Subject: Letter of support for Community Hubs as part of the Mental Health Services Act Innovations Grant considered by the El Dorado County Behavioral Health Commission

Dear Behavioral Health Commission,

The Behavioral Health Network of South Lake Tahoe (BHN) is committed to working with the Community Hubs to directly improve access to timely and responsive services for the most vulnerable members of the community. The BHN is focused on achieving three "pillars" of service which we believe directly align with the purpose and intention of the Community Hub system:

1. Enabling individuals seeking services to easily access them and take ownership of their health.
2. Fostering a community of care and a support system empowering community members to make the most of the services available to them.
3. Providing safe and secure connections between a comprehensive network of service providers on a common technology platform.

We appreciate that the Community Hubs focus on relationships as key at the community level which is specifically aligned with the BHN priority focus on building "connections" based upon relationships with specific under-served community groups. Further we value the Hub attention to fostering resilient families by emphasizing the" five protective forces". This strategy works in close concert with the BHN focus on fostering resilience through mental wellness, amelioration of substance dependencies, and addressing the "whole person" by supporting individuals and families through "wrap around" social services.

The BHN is a community wide "no wrong door" model which includes active partnership with Hub Teams in connecting clients to services, especially those that support prevention, early screening, identification and referral for mental or behavioral health services as identified through consistent screening and referral practices. On behalf of the 20+ organizations, 46 licensees, and 104 BHN network members we offer our unequivocal support for these essential Community Hubs.

Michael Ward

Michael Ward, Network Director
Behavioral Health Network of South Lake Tahoe

South Lake Tahoe
Family Resource Center

April 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Peter Spellman
Chairperson
Community Member

Tere Tibbetts
Lake Tahoe Community College

Virginia Matus-Glenn
Vice-Chairperson
Retired Principal

Jay Conroy
Community Member

Mike Connolly
Community Member

Mireya Ortega, DDS
Community Member

Joshua Buck
Community Member

Dear Commission Members,

I am writing this letter in support of the Mental Health Hub in South Lake Tahoe. Our Hub has provided support and information to our Spanish speaking community in their native language. Our Hub has provided culturally appropriate support on a wide variety of issues surrounding our community such as; mental health and services, medical and dental care options, and reading programs.

The HUB 5 has been a success for our Hispanic community. The bilingual staff have done a wonderful job at reaching out into the community ie: meeting at local community offices such as the Family Resource Center, participating and showing up at community events, soccer tournaments, Cinco de Mayo. The staff has also gone out of their way to meet our community after traditional work hours. The Hispanic community appreciates that the staff are long standing members of our community and feel welcomed.

I am pleased to support the El Dorado Community Hubs.

Sincerely,

Bill Martinez
Executive Director

3501 B Spruce Ave. * South Lake Tahoe, CA 96150 * PHONE: (530) 542-0740 * FAX: (530) 542-0397
www.tahoefrc.org
Tax ID #94-2284118

New Morning Youth & Family Services

Changing lives, Restoring hope. A tradition of caring since 1970.

David Ashby
Executive Director

Directors:

President
Matt Arenchild, Ph.D.
Economist
Director, Navigant Consulting
El Dorado Hills

Vice President
Donald P. Sacco
Consulting Services
El Dorado Hills

Treasurer
Michael Cozakas
Founder
Eagles Heart Charity
El Dorado Hills

Secretary
Gabrielle Marchini
Director of Programs &
District Support
El Dorado County
Office of Education

Thomas D. Cumpston
Attorney at Law
Placerville

Elizabeth Dawson
Engineering Manager
El Dorado Irrigation District
Placerville

Carl Hagen
Insurance Agent
Placerville

Kristine L. Kiehne
Consultant Retired
Placerville

John Mooney, D. C.
CEO, Premier Healthcare
Placerville

Barbara Newman
Attorney at Law
Newman & Broomand, LLP
Folsom

George Nielsen
Ret. Chief of Police
City of Placerville

Dion Nugent
CEO
Forté Holdings
El Dorado Hills

James Taylor-Bockmann
Distributor Sales Manager
Anchor Brewing Co.
San Francisco

April 17, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Commission Members:

On behalf of New Morning Youth & Family Services and the over 1,000 youth and families that we will serve this year I add my request that you continue funding support for the Community Hubs. While I will not repeat adding the number of families that the Hubs have provided services to this past year or the funding that is leveraged to help support those families who are taking advantage of the Hubs to strengthen their families I will offer my own brief perspective on just one instance where we have found the Hubs important to our efforts to bring mental health services to the community:

New Morning has been aware of limited transportation and internet access, to our families living in remote areas of our County, as barriers to accessing mental health services for children and youth in our County. When this was discussed at the Georgetown Divide ACEs meeting, it suggested that the Georgetown Divide Hub could be of assistance for the children on the Divide. What developed was a referral system where referrals for mental health services could be forwarded to the Hub and they could provide outreach to the family, and engage them through the HUB, including having our agency's Intake paperwork sent to the HUB, in which they could help the parent complete. This in just one example where a Hub was solution focused and a superb community partner.

We are all in the same focus area – trying to bring needed services to our community's youth. Please continue your support of the Hubs.

Sincerely,

David Ashby
Executive Director

ASPIRE to Excellence® carf ACCREDITED

Main Office
6765 Green Valley Rd, Placerville, CA 95667
Phone: 530.622.5551 fax: 530.622.5800
www.newmorningyfs.org

Emergency Childrens Shelter
Phone: 530.626.4190
Fax: 530.626.4193

Early Childhood Counseling Center
Phone: 530.622.5551
Fax: 530.622.5800

Pollock Pines-Camino Rotary Club
P.O. Box 88
Pollock Pines, CA 95726
www.pollockpines-caminorotary.org

April 18. 2019

EDC Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Commissioners,

Research tells us the higher number of Adverse Childhood Experiences (ACEs) impacts health outcomes. A 2012 Kidsdata.org report shows children in the county have two or more ACEs. The research also tells us, children living in resilient families are more likely to overcome ACEs. Community Hubs are an innovative approach to building resilient families.

Data from the 2018 Community Hub Profile shows the communities of Pollock Pines and Camion, part of Hub 3, struggle with substance abuse, mental health risks and increased health risks for Latino families. We have 359 grandparents living with their own grandchildren with 35% of those responsible for their care. The average unemployment rate is 14% and 15% of children live in poverty. We need to find new ways to reach and support our families.

Community Hub Teams work in our communities to reach families that are isolated, develop relationships and connect them to critical services.

The Pollock Pines/Camino Rotary supports Community Hubs and believes this strategy works well in rural communities.

Sincerely,

Ginger Swigart, President
Pollock Pines/Camino Rotary
gingerswigart@att.net

Tahoe Valley Elementary

OFFICE
943 Tahoe Island Drive
South Lake Tahoe, CA
96150

PHONE
530-543-2350

FAX
530-543-2362

PRINCIPAL
Christina Grubbs
M.Ed., NBCT

April 4, 2019

To Whom It May Concern,

My name is Fred Buttrick. I am a school nurse at Tahoe Valley Elementary School in South Lake Tahoe. I am writing in support of expanding the services provided by Hub 5 for the South Lake Tahoe community. I have utilized El Dorado County Health Nurses for outreach to my students' families, whether it's facilitating a transition in insurance coverage, obtaining medical or dental services.

I'm learning daily about how the integrated Hub 5 system offers a wraparound approach to helping families in need. The mental health component is especially important to hub services, as families may not be aware that help through counseling and intervention are available. 75% of the families in our student population are below poverty level income. These financial stressors directly affect our student's ability to learn and the parents' ability to help their children learn.

Teaching parents and children cognitive behavioral techniques can be a stepping stone to wellness and better overall health. The Public Health Nurse referrals at Tahoe Valley Elementary help us reach out to our families in the privacy of their own homes. Parents can open up to the nurse and share concerning issues through casual conversation, without feeling self -conscious as in a public setting.

Please consider expanding Hub 5's outreach capabilities and mental health services to better serve my students and their families.

Thank you,

Nurse Fred, RN BSN

SOAR

Where the ARTS come ALIVE!

NEWS RELEASE

Chief Administrative Office
El Dorado County

EL DORADO COUNTY WINS AWARD FOR OUTSTANDING PROGRAM

FOR IMMEDIATE RELEASE
September 9, 2019

CONTACT: Carla Hass
(530) 621-4609

(PLACERVILLE, CA) – El Dorado County's Community Hubs programs received an award from the California State Association of Counties (CSAC) recognizing it as an exemplary and innovative service to the community.

The Community Hub program is located in each of the five supervisorial districts, using the local library as a "hub" to provide prevention and early intervention services to families. The Hubs are comprised of a multidisciplinary team including a public health nurse, a community health advocate, a family engagement specialist and an early childhood literacy specialist. It is a collaborative effort between the Health and Human Services Agency, County Libraries, First Five, and El Dorado County Office of Education.

"The Community Hubs offer families with newborn children to age 18 the opportunity to learn about child development, parenting, the importance of literacy and many other issues facing families today," said Health and Human Services Agency Director, Don Semon.

The Hubs have served more than 6,000 children age zero to five and almost 5,000 parents and caregivers in the last two years. In 2018, Hubs have provided almost 900 literacy activities, nearly 200 family engagements and connected close to 900 families with health providers.

"Libraries are a natural choice to locate the Hubs because families regularly use them and feel safe there," said Library Director, Jeanne Amos. "By offering these services and information here, we connect with families and children who may otherwise not visit a government office."

CSAC's annual statewide program honors innovation and best practices in county government. This year, CSAC received 284 entries – the second largest number in the program's history. An independent panel of judges with expertise in county programs selected the award recipients.

You can learn more about the Community Hubs here:

https://www.counties.org/sites/main/files/file-attachments/eldoradoco_communityhubs93.pdf

For more information about the CSAC Challenge Awards, click here.

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Providing safe, healthy and vibrant communities; respecting our natural resources and historical heritage.

Heather Longo <heather.longo@edcgov.us>

[MHSA] MHSA Annual Update for BOS meeting 6/25/19 at 11am

1 message

Valerie Akana <vakana@alumni.gsb.stanford.edu> Tue, Jun 18, 2019 at 5:21 PM
To: EDC COB <edc.cob@edcgov.us>, HHSA-MHSA-m <mhsa@edcgov.us>

Hello,

I would like to have this email submitted as a public comment on the MHSA Annual Plan Update which is to be heard by the Board of Supervisors on 6/25/19 at 11am. There is no agenda yet published so I don't know what the agenda item number is...

I fully support the MHSA Plan as proposed by Human Services staff. I especially want to state my support for the Community Hubs project in particular, because there has been much concern expressed by some of the Behavioral Health Commission members as to whether or not this project should be funded by MHSA funds. As I understand it, the Community Hubs project is classified as a MHSA "innovation" project and has already been blessed by the State MHSA team. Getting the State to bless an innovation project is no easy feat and I believe that we should be grateful that this project was approved and thank our staff for their expertise and skill at getting the State to approve it.

Per the State's criteria, an innovation project must advance our learning in some way and I believe the investment in the Hubs has the potential to teach us a lot. In addition, if we do not continue to move this project forward, it is possible that we will lose this funding and it will revert to the State pot. That would be a shame because I believe the Hubs can teach us a lot about how to prevent childhood trauma, and thus one of the environmental factors contributing to mental illnesses. I know that for my family in particular, had there been a Community Hubs program when my youngest siblings were growing up in a severely traumatizing environment, they might have had a better chance of developing resiliency, instead of severe mental illnesses.

My hope for the Community Hubs is that they are so wildly successful, that we eventually eliminate the need for behavioral health services in our County, at least for mental illnesses due in large part to childhood trauma. And, with the Hubs, I hope we could also identify the early signs of organic mental illnesses so that we could try to keep them from becoming severely debilitating for our kids and families. Thank you.

Sincerely,
Val Akana
Placerville

---------- Forwarded message ---------
From: **MHSA El Dorado** <mhsa@edcgov.us>
Date: Mon, Jun 17, 2019 at 1:45 PM
Subject: Re: [MHSA] MHSA update at Board meeting
To: Valerie Akana <vakana@alumni.gsb.stanford.edu>
Cc: HHSA-MHSA-m <mhsa@edcgov.us>

Hello Val,
Thank you for your email. The MHSA Annual Update will be presented to the Board of Supervisors on Tues., June 25 at 11 a.m.

Thank you,
Heather

On Fri, Jun 14, 2019 at 7:53 PM Valerie Akana <vakana@alumni.gsb.stanford.edu> wrote:
Hi All,

> Could you please refresh my memory as to the date/time that the Board of Supervisors will hear the MHSA plan update? I want to submit a letter for this item to the Board Clerk in advance of the meeting.
>
> Thank you! Sincerely, Val Akana

WARNING: This email and any attachments may contain private, confidential, and privileged material for the sole use of the intended recipient. Any unauthorized review, copying, or distribution of this email (or any attachments) by other than the intended recipient is strictly prohibited. If you are not the intended recipient, please contact the sender immediately and permanently delete the original and any copies of this email and any attachments.

From: Stephen Clavere <steveclavere@comcast.net>
Sent: Saturday, May 11, 2019 2:03 PM
To: Desormeaux, Wendy@MHSOAC <Wendy.Desormeaux@mhsoac.ca.gov>
Cc: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>; Shah, Sharmil@MHSOAC <Sharmil.Shah@mhsoac.ca.gov>
Subject: RE: Community Based Engagement and Support Services project

Thank you for your assistance and prompt reply to my phone call last Thursday. I would like to convey to you and the INN project staff that the El Dorado Behavioral Health Commission has serious concerns regarding the viability and justification of the Behavioral Health contribution to the Community Hubs Project. In fact, we have assigned this extension request to an Ad Hoc Committee to address these very issues, which is scheduled to report their recommendations at our May meeting. I can advise you of the commission's decision shortly thereafter. Please consider our concerns as you deliberate, and let me know if you need any further information.

Steve Clavere, Ph.D.
Chair, El Dorado County
Behavioral Health Commission

From: Jeanne Nelson <f2fnami@gmail.com>
Sent: Monday, July 29, 2019 4:59 PM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>
Cc: Pate, Norma@MHSOAC <Norma.Pate@mhsoac.ca.gov>; Fred Hjerpe <hjerpef@gmail.com>
Subject: Misappropriation of Innovation MHSA$ in El Dorado County; greater governance and measures requested please

Dear MHSOAC Commission Chair,

Will you please direct this to the most appropriate contact within your commission for next steps?
I have also reached out to Gavin Newsom's new Mental Health Czar, Dr. Thomas Insel in parallel.

Funds were provided to El Dorado County for Community HUBS as an Innovation project. Many concerns were raised at multiple BH Commission meetings questioning rationale for using precious MHSA$ on something we view should be funded purely by the county as part of the county's organic business evolution. But since funds were appropriated there must be governance to ensure what was promised is delivered. There is a strong county leniency tone where rules don't apply because this is an Innovation project - where they seem to believe they can learn as they go.
That said, what was promised in order to gain initial MHSA$ has not been delivered AND now additional MHSA$ are being awarded with still no course correction.
This feels very much like a non-malicious bait and switch. Nurses were promised and not delivered. Measures of mental health referrals were assured but not delivered.
Public health nurses at actual physical HUBS were assured. Instead staff workers (not nurses) have been provisioned and HUBS themselves have evolved from their original commitment.

Our affiliate has been in operation for 23 years serving El Dorado County community. This post on our website further details our concerns.

Findings from an El Dorado County grand jury investigation of MHSA$ was made public last month. We feel our county should return MHSA$ for appropriation to other counties that can demonstrate evidence that they are on-track with advertised commitments / measures.

Our little all-volunteer NAMI affiliate receives approximately 700 calls for support every year. Our newsletter has nearly 1000 subscribers and about a 50% readership rate. We are well connected with the local hospital and providers and gaining traction in the schools. Every dollar is precious and we appreciate your role in ensuring oversight and accountability.

Thank you for your consideration in advance.

Cheers,

Jeanne Nelson
President, NAMI El Dorado County
namieldoradocounty.org
FACEBOOK: NAMI El Dorado County "like us" and NAMI El Dorado "friend us"
Warm-line: (530) 306-4101

Cc: Fred Hjerpe, Co-President NAMI El Dorado County

NAMI
National Alliance on Mental Illness
El Dorado County

From: Stephen Clavere <steveclavere@comcast.net>
Sent: Tuesday, August 27, 2019 1:54 PM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Cc: Shah, Sharmil@MHSOAC <Sharmil.Shah@mhsoac.ca.gov>; Desormeaux, Wendy@MHSOAC <Wendy.Desormeaux@mhsoac.ca.gov>
Subject: RE: Community Based Engagement and Support Services project

Thank you for an opportunity to respond. With regard to your three questions:

- There is no evidence that the comments I provided during the Behavioral Health Commission (BHC) meetings were in any way incorporated into the final plan. In fact during the meetings, Health and Human Services Agency (HHSA) staff replied they were not relevant.
- Yes, I believe the serious concerns regarding the viability and justification of the project remain not only as serious obstacles to the project itself, but also as a hindrance to the reasoned and

empirically valid distribution of MHSA funds to the county as a whole in accordance to the original intent of the Mental Health Services Act (MHSA).

- Yes, the BHC did approve the MHSA update which included the Hub extension request. However, the approval appeared to have not been granted on the merits of the program as described in the attached proposal. Rather, the argument that swayed the majority of commissioners was the HHSA plea that if the project was not approved, the unspent funds would be returned to the Mental Health Services Oversight and Accountability Commission (MHSOAC), and would not be spent improving services to our Seriously Mentally Ill (SMI). So then, why not? What was not stated was the fact that the county should have been more proactive and responsive to the needs of the community, and the funds could have been spent in prior years for INN projects that would have better served the SMI. The minority commissioners, whose view I am representing, believe that in order to maintain the integrity of the MHSA, funding for ill conceived projects should not be allocated simply to avoid returning them to the MHSOAC.

Additional Information:

This project will only fund staff in Public Health Job classifications to perform Public Health duties. In addition, the extension will also fund county Education Department job classifications to perform Education Department duties. Not a single new Mental Health position will be created. For all I know, this may be a common practice throughout the State to divert MHSA funds for the expansion of other county agencies/departments without any significant statistical outcome basis. I hope not.

The extension proposal states on page 14, while acknowledging "anecdotal reports" and "limited data," that, "... the impact to mental health services is not yet fully understood." That assertion is highly inaccurate. In fact, the impact to mental health services is clearly understood. Tracking referrals are used to measure success for half of the project objectives (1,3 & 5), and is particularly focused on mental health services. The data presented on pages 6 and 7 of the proposal show a total of 48 out of 824, or 5.8% of the public health referrals were made for mental health services, with an expenditure of $672,375 ($14,000 per referral). For a county population of approximately 189,000, this represents a trickle, and is well within the statistical margin of error for that population. Therefore, the impact to mental health services is miniscule. A fiscal analysis shows that for the past four years, MHSA funds have been budgeted for 40% of the Community Hubs cost, for a 5.8% share of the referrals. If the extension is approved, this will increase to 54.5% of the cost, a vastly disproportionate return on the expenditure.

To reiterate, I represent the minority position on the commission. However, this position is shared and endorsed by the National Alliance on Mental Illness (NAMI), El Dorado. I will forward their letter in a separate email.

Steve Clavere, Ph.D.
Chair, El Dorado County
Behavioral Health Commission

NAMI El Dorado County

National Alliance on Mental Illness

12-August-2019

To: MHSOAC Chair and MHSOAC Members

On behalf of our entire Board of Directors we wish to thank you for your leadership and service ensuring careful governance of the MHSA and MHSA funds.

> *"More than 2 million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California. Thirty years ago, the State of California cut back on its services in state hospitals for people with severe mental illnesses, without providing adequate funding for mental health services in the community. Many people became homeless.*
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> *To address this issue, Proposition 63 was approved by voters in 2004. Proposition 63, also called the Mental Health Services Act, was enacted into law on January 1, 2005. It places a 1% tax on personal income above $1 million; since that time, it has generated approximately $15 billion." MSOAC The Act*

The key words here are *disabling, severe, adequate funding, homeless*. The MHSA was passed by voters in response to the cut backs in state funding for the severe mentally ill without providing adequate funding for community mental health programs.

El Dorado County has received millions of MHSA funds to increase services to this population (~7%). While there have been significant increases in some areas; adult and child Full-Service Partnerships, Intensive Case Management for the most severe, and the Wellness Center program to address the social needs, the total number of individuals served with severe and persistent mental illness remains well below the statistical average of expected cases. For individuals and families attempting to get help, assistance, and treatment for themselves or their loved ones, the road is long and frustrating with too many interactions with law enforcement, the criminal justice system and homelessness. It is especially frustrating that we find that EDC has failed to utilize all of the available MHSA funds and may need to return unspent funds to the state. There are many reasons for this, some of which are due to the very nature of the rigid, fragmented, and restrictive mental health system as it exists everywhere as well as the challenges of a county government bureaucracy that struggles with contracts and wage and hiring practices.

The MHSA was enacted with the best of intentions. However, there are many fault lines that soon developed once counties began developing their programs. These are some of the issues:

1) **Not enough psychiatrists, trained professionals, and line staff to the meet the needs of expanding programs under MHSA statewide, with smaller counties losing out** to the better paying larger wealthier counties. The WET component was inadequate from the start and very difficult for smaller counties to utilize.
2) **Capital and Technology funding depended on county governing bodies** to incorporate zoning, budgets, and existing technology and infrastructure to expand and improve facilities and technologies in use. Small counties have limited options. This has been a long slow and confusing process, especially in utilizing funds for buildings and facilities.

3) **The Innovation Component is impossibly difficult to manage**. So many wasted hours in trying to come up with a plan that, "*never has been tried before*", affects the targeted population positively, and can be sustained.
The "Community HUB" Innovation plan currently in place is an example of innovation that only indirectly affects, if at all, the targeted population of MHSA, and is largely a broad community public health program. Worthwhile, but hardly an innovation that is going to positively improve access to treatment for the severely mentally ill. The "Hubs" were located in our county libraries, which is a logical location given they are frequented by community members needing respite from weather and the vagaries of living with a mental illness. At no time since this program was enacted, has there been provided consistent, reliable, connections to assistance for community members in psychiatric/emotional distress at the HUBS. Concerned library staff are more likely to turn to law enforcement, rather than directing individuals to the Hub station for resources, references, assistance, and empathy.

Kiosks (Mental Health Resources) were offered at no cost to all HUB locations by NAMI El Dorado County, but only two accepted the literature racks which are provided free and stocked monthly by our volunteers with high quality educational brochures and community resources. The reason given was the lack of space for the approximate 24 to 36 inch wide quality literature racks that sit on the floor.

These are the questions posed by the El Dorado County MHSA plan for the Community HUBs project:

- **Does providing services at the library reduce stigma?** *Not if the staff are still relying on law enforcement to "assist" homeless mentally ill in distress. That increases the stigma. PHN's are not provisioned at the library.*
- **Does increasing access to prevention and early intervention reduce long-term mental health costs?** *How do you measure this? SMI is not preventable, but early intervention can reduce the lifelong impact of these conditions. Early intervention should include education of symptoms and signs, crisis care, family support, and housing if needed. Most people do not think of mental illness until it occurs. Early intervention needs to address immediate needs to mitigate the long-term deleterious effects of psychosis, repeated hospitalization, loss of executive function, loss of self-esteem and confidence, and risk of homelessness. There is no indication that the HUB program provides this assistance except peripherally.*
- **Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?** *Hard to measure, but it's known that SMI impacts the physical health of individuals. A bias among providers exists that those with SMI will not take care of themselves and so may be reluctant to provide services. With the ACA in effect and the availability of Medi-Cal, getting folks to attend to teeth, eyes, metabolism, etc. should be a regular part of their care. People with serious mental illness may not be aware of their own needs and need assistance in locating providers and setting up appointments. Is this something the HUBS provide?*

- **Does case management by a Public Health Nurse increase client screening and treatment for mental health services?** *Hubs are not set up for this kind of service on a consistent basis. PHN are not necessarily skilled in MH assessments. Rather than a public nurse, a mental health clinician could be on call or rotate between Hubs to provide mental health assessments and would be less expensive and easier to recruit. The PHN's promised as part of the HUB program have not been delivered on. To that end, case management is an essential part of care for SMI, but the case management as provided by these HUBS is not likely to provide the necessary level of care. Assistance for individuals in finding providers and setting up appointments would be helpful. See above question.*
- **Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?** *Having a serious mental health condition is, by its very nature, a trauma. Focusing on the secondary impacts of trauma on a vulnerable individual with a family history of mental illness would be beneficial. However,* ***seeking environmental reasons for a hereditary condition and assuming environmental*** *causes may not be helpful. Please refer to NIMH, BBRFoundation.org and our current NAMI El Dorado County Crucial Conversation brochure (https://namieldoradocounty.org/crucial-conversations-brochure-and-poster/) approved by our local psychiatrists and something we are proactively sharing with teens/tweens in partnership with select local schools.. What governance is being applied to MHSA$ recipients to ensure basic understanding about hereditary condition of serious mental illness?*
- Can Community Hubs be sustained through local planning and leveraging of resources? *As long as resources are not pulled from essential areas.* ***Behavioral Health needs to be included in leveraging community resources, but it should not be losing resources to satisfy a broad-based feel-good program that diverts dollars to areas less in need.***

The county is investing considerable MHSA funds for this program. The benefit for those dollars should be to our county's system of care for the severely mentally ill. **At this time, the HUBS Innovation Plan does not seem to have a clearly defined connection to the MHSA intent and the data gathered in the first 3 years of this program does little to provide evidence to the contrary.** Similarly, some members of our county's Behavioral Health Commission were informed that county clients would suffer if the commission did not support the plan to expand funding for the Community HUBS; this is not in line with reality. The Commission was encouraged to support the HUB funding expansion using MHSA$ as it was encouraged as a perceived better option than returning the money to the State for redistribution to other counties. We support re-distribution to adhere to the purpose set forth by MHSA.

We are asking for your governance help please.

With appreciation,

Jeanne Nelson
President, NAMI El Dorado County
Jeanne's Personal Cell: 650-740-5776
Namieldoradocounty.org
E2ENAMI@gmail.com
Warmline: 530-306-4101

Jan Melnicoe
Past President, NAMI El Dorado County

NAMI El Dorado County

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12-August-2019

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Jan Melnicoe
Past President, NAMI El Dorado County

AGENDA ITEM 2

Action

January 23, 2020 Commission Meeting

Youth Drop-In Centers Outline for Request for Application

Summary: The Commission will consider approval of a Request for Application (RFA) to support Youth Drop-In Centers. The Request for Application is a competitive bid process that would distribute $10 million to support Youth Drop-In Center programs. An additional $4.5 million to provide technical assistance would be made available separately.

Background: The 2019-20 budget includes $14,589,000 in state funds to support the development of youth drop-in centers that provide integrated mental health services for individuals between the ages of 12 and 25 years of age and their families. The focus of these centers are to be on vulnerable and marginalized youth and disparity populations, including but not limited to LGBTQ, homeless and indigenous youth.

The Request for Application (RFA) outline includes the allocation of funding as well as the components of the applications for the grants to support Youth Drop-In Centers.

Stakeholder Engagement: To inform this proposed outline the Commission held a focus group on December 17, 2019 involving youth with lived experience and a listening session on January 9, 2020. The listening session was designed to gather feedback regarding the best approach to allocating funds and supporting the development of Youth Drop-In Centers. Participants included youth, county behavioral health departments, youth programs, and representatives from educational organizations.

Common themes in these discussions included:

- Participation of youth in the planning, implementation, and on-going service delivery is a critical component
- Youth center location and accessibility is important to reaching youth
- Technical Assistance and Training is needed to implement programs with fidelity
- Planning grants and program grants should be considered
- Programs should include trauma-informed staff

In recognition of the need to support communities that are at a planning stage and others that are ready to implement, Commission staff are recommending a set aside of funds for technical assistance and planning support ($4.5 million) and funding for program implementation ($10 million).

The Commission will consider the approval of funds for technical assistance and planning support in Item 4 of the Commission's agenda.

Presenter: Tom Orrock, Chief of Commission Operations and Grants

Enclosures: (1) Proposed Outline of Request for Application (RFA) for Youth Drop-In Centers

Handouts: A Power Point will be provided at the meeting.

Mental Health Services
Oversight and Accountability Commission

Outline for the Youth Drop-In Centers Request for Applications

Background

The Commission was provided $14,589,000 through the Budget Act of 2019 to support the establishment or expansion of integrated mental health youth drop-in centers which provide mental health and wellness services for individuals between 12-25 years of age and their families. These programs will be equipped to meet the needs of youth, including mental and behavioral health needs, housing, education and employment support, and linkage to other services. The Budget Act called for a focus on vulnerable and marginalized youth and populations of youth with known disparities e.g. LGBTQ, homeless, and indigenous youth.

The Commission is authorized to establish criteria for the release of these funds. Those criteria can include consideration of gaps in local service delivery systems, availability of matching funds, ability to document key outcomes associated with the use of the funds, level of youth and community involvement and other criteria.

The availability of these funds builds upon the internationally recognized *headspace* model of Australia and the work of Santa Clara County to adapt that model through the development of the allcove program. Santa Clara has developed the allcove program with input and leadership of youth using MHSA Innovation funds.

Under the terms of the Commission's budget allocation, funds are available over a four-year period and the Commission has discretion in determining who is eligible to receive these funds, how they can be used and how they are awarded.

Funding can be used for technical assistance, program monitoring and evaluation.

Authorizing legislation is clear that these funds can be used to build upon and extend the impact of existing programs and funding but cannot be used to supplant local funding for existing programs.

Current Efforts

Over the past several years, the Commission has prioritized the needs of children and youth in program implementation efforts as well as expansion of youth voice in the development of new programs. In 2017, the Commission responded to the need for mental health crisis programs for children and youth by authorizing the release of SB 82 Crisis Triage funds, with 50 percent of those funds dedicated to children and youth aged 21 and under. Of those funds, $20 million was set aside to support four School-County Collaboration Triage grants. With this effort, the Commission has provided funds to support research, evaluation, and technical assistance to counties serving children and youth.

In February 2018, the Commission hosted an innovation summit to connect California's mental health stakeholders with some of the state's leaders in human-centered design. This event led to the formation of the Youth Innovation Project Committee which is currently hosting Idea Labs in three regions of the State to generate innovative solutions which will address the gaps in care available to youth.

As mentioned above, in August 2018, the Commission approved Santa Clara County's Innovation plan for $14.9 million over four years to launch the allcove program which builds upon Australia's *headspace* project. This project is in its planning and early implementation phase and aims to increase access to mental health and wellness services for individuals between the ages of 12-25. Services include:

1. Behavioral health (mental health and substance use treatment)
2. Physical health/Primary care
3. Educational support
4. Employment support

Funding Allocation:

The proposed funding for this Request for Application is $10 million to be set aside to support Youth Drop-In Centers programs and $4.5 million to provide technical assistance to grantees and other interested organizations.

Staff recommends that the Commission apportion funds in the amount of $4,589,000 to a Technical Assistance contractor who will support grantees, ensure program quality, and assist the expansion of youth drop-in centers across the state by:

1. Assisting the program grant recipients with implementation, training, data collection coordination, and youth-driven design strategies.
2. Assist all interested organizations who applied but were not awarded through this grant to explore other opportunities which may exist to support additional programs.
3. Assist all interested counties who wish to explore opportunities for the implementation of youth drop-in centers in their communities.

Staff recommends the Commission apportion funding for program grants for up to $2 million per grant over the four-year grant term.

Youth Drop-In Centers Request for Applications Outline

Available funding for the grants is $10,000,000 of one-time funding to support the goals of the Youth Drop-In Centers. An incentive will be included for matching funds.

I. Eligibility

County, city, or multi-county mental health or behavioral health departments, including multi-county partnerships, non-profit organizations, or educational entities may apply for a grant. Funds may be used to supplement but not supplant local funding for youth drop-in centers.

II. Minimum Qualifications

Applicants must meet the minimum qualifications below in order to be eligible for this funding opportunity. The purpose of establishing these minimum qualifications is to ensure that the entities applying for funding are adequately experienced and have the capacity to perform the duties as outlined.

1. At least two years of experience providing mental health services to youth ages 12-25.
2. At least one year of experience partnering with youth on projects related to mental health and wellness.
3. If an applicant is not a County, city, or multi-county behavioral health department the applicant must be a not-for-profit organization and be designated by the County, city, or multi-county behavioral health department to apply.

III. Program Grant Funding and Term

$10 million will be made available for program grants and approved for a grant term of up to four years, with funds allocated annually, in quarterly installments contingent on fulfilling reporting requirements.

IV. Key Action Dates

RFA Release	January 31, 2020
Intent to Apply	February 7, 2020
Application Due Date	March 27, 2020
Intent to Award	April 23, 2020

V. Allowable Costs

Grant funds must be used as stated in the applicants submitted by the awardee and approved by the Commission, as follows:

1) Allowable costs include personnel, administration and program costs.
    a. A budget worksheet shall be submitted with the applications which outlines all planned expenditures, amounts, and time frames for personnel hire dates, administrative cost expenditures, and program costs including training, technology, transportation and facilities.
2) Grant funds may be used to supplement existing programs but may not be used to supplant existing funds for school-based mental health services.
3) Grant funds cannot be transferred to any other program account for specific purposes other than the stated purpose of this grant.

VI. Youth Drop-In Center Program Plan

The Program Plan must demonstrate the Applicant's ability to meet all specified qualifications, requirements, and standards set forth in the RFA. The Program Plan will include, among other things, a description of the need, including potential gaps in local services as well as how the program will operate within the county's continuum of mental health and behavioral health care for youth ages 12-25.

VII. Program Implementation Plan

The Commission will require the applicants to submit a Program Implementation Plan as a part of the application. The Program Implementation Plan outlines the steps which will be taken by the applicant and will address any known barriers to implementation.

VIII. Program Communications Plan

Applicants must include a description of the communication plan which will increase awareness of the services in the community or region where they exist. The plan will outline how youth, families, providers, educational entities and other community-based organizations will be made aware of the program services. As a result, the Commission will require that the youth drop-in centers maintain up to date information on their website(s).

IX. Budget Requirements

Applicants must provide budget information, as indicated, on the Budget Worksheet, which will be provided with the RFA. Budget detail is required for personnel costs, program costs and administration.

X. Program Evaluation

In order to determine program success, awardees are required to collect and provide data on the specific measures as outlined by the Commission.

AGENDA ITEM 3

Action

January 23, 2020 Commission Meeting
Overview of the Governor's 2020-21 Proposed Budget

Summary: The Commission will be presented with an overview of the Governor's Proposed Fiscal Year 2020-21 Budget as it relates to mental health.

Background:

The Governor's Proposed Budget states that it will advance key health and human services priorities including quality, affordable health care regardless of age or income; transformed health care services through the Medi-Cal program; lower prescription drug costs; integrated behavioral health care services; and support for those who struggle with homelessness. Priorities include:

- improving outcomes for the state's behavioral health system through investments that improve the integration and parity between behavioral health treatment and physical health care. (CHHS Page 30)

- establishing a Behavioral Health Task Force to review existing policies and programs to improve the quality of care, and coordinate system transformation efforts to better prevent and respond to the impacts of mental illness and substance use disorders in California communities. (CHHS Page 30)

- updating the Mental Health Services Act to focus on people with mental illness who are also experiencing homelessness, who are involved in the criminal justice system, and for early intervention for youth. (CHHS Page 31)

- launching a Medi-Cal Healthier California for All Initiative that proposes to provide a wider array of services and supports for patients with complex and high needs. (CHHS Pages 32-34)

- establishing Community School grants in the amount of $300 million one-time funds for local educational agencies supporting innovative community school models. (K-12 Edu. Page 67-68)

Presenter: John Connolly, Deputy Secretary, Behavioral Health, Health and Human Services Agency

Enclosures (2): Health and Human Services Summary and K-12 Education Summary from the Governor's Proposed 2020-21 Budget.

Handouts: None

Additional enclosures for Agenda Item 3 “Overview of the Governor’s 2020-21 Proposed Budget” can be found at the following link:

Governor’s Budget Summary 2020-21

Health and Human Services Summary – page 23

K-12 Education Summary – page 67

AGENDA ITEM 4

Action

January 23, 2020 Commission Meeting
Overview of the Commission's 2021 Proposed Budget and the Commission's 2019-20 Expenditures

Summary: The Commission will receive an update on its Fiscal Year 2019-20 Operations Budget and the Governor's proposed Fiscal Year 2020-21 Operations Budget for the Commission.

Background:

Fiscal Year 2019-20
The Commission will be presented with the mid-year expenditures for its 2019-20 Budget. The total budget in 2019 was $122.4 million, which included $102 million for local assistance.

The Local assistance budget included:

- $20 million one-time funds for Early Psychosis Detection and Intervention;
- $15 million one-time funds to develop mental health drop-in centers for youth;
- $40 million one-time funds for partnerships between county mental or behavioral health departments and K-12 schools;
- $10 million ongoing funds to encourage collaboration between county mental health or behavioral health departments and K-12 schools; and
- $20 million ongoing funds for the Triage grant program.

The budget also included $2.5 million for the Innovation Incubator and $5.4 million for stakeholder advocacy efforts.

Fiscal Year 2020-21
The Commission will be presented with the Governor's 2020-21 Budget proposal for the Commission. The budget proposes $45 million for Commission Operations in 2020-21, which includes $29 million ongoing funds for local assistance for Triage grants and the Mental Health in Schools Services Act grants.

Presenter: Norma Pate, Deputy Director

Enclosures: None.

Handouts (1): A PowerPoint will be provided at the meeting.

AGENDA ITEM 5

Information

January 23, 2020 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission.

Presenter:

- Toby Ewing, Executive Director, MHSOAC

Enclosures (5): (1) Motions Summary from the November 21, 2019 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) Calendar of Tentative Agenda Items; (5) Department of Health Care Services Revenue and Expenditure Reports Status Update;

Handouts: None

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
November 21, 2019

Motion #: 1

Date: November 21, 2019

Time: 9:47 AM

Motion:

The Commission approves the September 26, 2019, Meeting Minutes as revised on pages 9 and 21 to reflect corrections to Poshi Walker's public comments.

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Berrick

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☐	☐	☒
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☐	☐	☒
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
November 21, 2019

Motion #: 2

Date: November 21, 2019

Time: 11:25 AM

Motion:

The MHSOAC adopts Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025, including direction to staff to seek funding and to work with Commissioners Danovitch and Gordon to address their concerns.

Commissioner making motion: Commissioner Wooton

Commissioner seconding motion: Commissioner Danovitch

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
16. Commissioner Alvarez	☐	☐	☐
17. Commissioner Anthony	☒	☐	☐
18. Commissioner Beall	☐	☐	☐
19. Commissioner Berrick	☒	☐	☐
20. Commissioner Boyd	☒	☐	☐
21. Commissioner Brown	☒	☐	☐
22. Commissioner Bunch	☐	☐	☐
23. Commissioner Carrillo	☐	☐	☐
24. Commissioner Danovitch	☒	☐	☐
25. Commissioner Gordon	☒	☐	☐
26. Commissioner Madrigal-Weiss	☒	☐	☐
27. Commissioner Mitchell	☒	☐	☐
28. Commissioner Wooton	☒	☐	☐
29. Vice-Chair Ashbeck	☐	☐	☐
30. Chair Tamplen	☒	☐	☐

Motions Summary

Commission Meeting
November 21, 2019

Motion #: 3

Date: November 21, 2019

Time: 11:55 AM

Motion:

- The Commission approves the proposed outline for the Mental Health Student Services Act Request for Proposals.
- The Commission authorizes the Executive Director to initiate a competitive bid process.

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Commissioner Mitchell

Commissioners Berrick, Gordon, and Madrigal-Weiss recused themselves.

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☐	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
November 21, 2019

Motion #: 4

Date: November 21, 2019

Time: 2:22 PM

Motion:

- The Commission approves the proposed outline of the scope of work for six stakeholder RFPs to support advocacy, training, and outreach efforts on behalf of Clients/Consumers, Diverse Racial and Ethnic Communities, Families of Clients/Consumers, LGBTQ, Parents of Children and Youth, and Veteran Communities
- The Commission authorizes the Executive Director to initiate a competitive bid process.

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Brown

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☐	☐	☒
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
November 21, 2019

Motion #: 5

Date: November 21, 2019

Time: 3:13 PM

Proposed Motion:

The Commission adopts the amendments to the Conflict of Interest Code and authorizes the Executive Director to submit the Code with the supporting documentation as required by law.

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Berrick

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Summary of Updates

Contracts

New Contract: 19MHSOAC022

Total Contracts: **7**

Funds Spent Since the November Commission Meeting

Contract Number	Amount
17MHSOAC073	$0
17MHSOAC074	$0
17MHSOAC081	$0
17MHSOAC085	$33,469
18MHSOAC020	$23,700
18MHSOAC040	$145,126
19MHSOAC022	$290,004
Total	**$492,299**

Contracts with Deliverable Changes

17MHSOAC081

17MHSOAC085

18MHSOAC020

18MHSOAC040

The Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai Le Masson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $3,528,911.50

Total Spent: $460,000

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	In Progress	2/12/20	No
Formative/Process Evaluation Plan	In Progress	1/24/20	No
Data Collection and Management Report	Not Started	4/15/20	No
Final Summative Evaluation Plan	Not Started	7/15/20	No
Data Collection Implementation Progress Reports	Not Started	10/15/20	No

Deliverable	Status	Due Date	Change
Formative/Progress Evaluation Plan Implantation Reports and Summative Evaluation Implantation Progress Reports	Not Started	1/15/23	No
Statewide Conferences	Not Started	4/15/22	No
Midpoint Progress Report	Not Started	10/15/21	No
Revised Final Summative Evaluation Plan	Not Started	4/15/21	No
Data Quality Report and Summative Evaluation Progress	Not Started	4/15/22	No
Draft Summative Evaluation Final Report	Not Started	1/15/23	No
Final Report and Recommendations	Not Started	4/15/23	No

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai Le Masson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $3,528,911.50

Total Spent: $460,000

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	In Progress	2/12/20	No
Formative/Process Evaluation Plan	In Progress	1/24/20	No
Data Collection and Management Report	Not Started	4/15/20	No
Final Summative Evaluation Plan	Not Started	7/15/20	No
Data Collection Implementation Progress Reports	Not Started	10/15/20	No

Deliverable	Status	Due Date	Change
Formative/Progress Evaluation Plan Implantation Reports and Summative Evaluation Implantation Progress Reports	Not Started	1/15/23	No
Statewide Conferences	Not Started	4/15/22	No
Midpoint Progress Report	Not Started	10/15/21	No
Revised Final Summative Evaluation Plan	Not Started	4/15/21	No
Data Quality Report and Summative Evaluation Progress	Not Started	4/15/22	No
Draft Summative Evaluation Final Report	Not Started	1/15/23	No
Final Report and Recommendations	Not Started	4/15/23	No

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff: Katherine Elliot

Active Dates: 7/1/2018-7/31/2020

Total Contract Amount: $1,200,000

Total Spent: $510,300

The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to

1) negative outcomes of mental illness
2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes
3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden),
4) capacity of the service delivery system to provide treatment and support,
5) successful delivery of mental health services
6) population health measures for mental health program client populations.

Deliverable	Status	Due Date	Change
Work Plan	Complete	09/30/18	No
Survey Development Methodology/Survey	Complete	12/31/18	No
Survey Data Collection/Results/Analysis of Survey	In-Progress	3/30/20	No
Summary Report (3 Public Engagements)	Complete	3/30/19	No

Deliverable	Status	Due Date	Change
Summary Report (3 Public Engagements)	Complete	6/30/19	No
Outcomes Reporting Draft Report —3 Sections	Complete	9/31/19	Yes
Outcomes Reporting Draft Report – 2 Sections	In-Progress	12/31/19	Yes
Outcomes Reporting Draft Report –2 Sections	In-progress	1/31/20	Yes
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/18 - 3/31/19

Total Contract Amount: $234,279

Total Spent: $167,343

The intention of this pilot program is to work with a four-county sample (Amador, Fresno, Orange, & Ventura) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics

Deliverable	Status	Due Date	Change
Final Online Survey	Complete	02/04/19	No
FSP Program Data Sets	Complete	05/06/19	No
FSP Formatted Data Sets (Amador & Fresno)	Complete	09/07/19	Yes
FSP Formatted Data Sets (Orange & Ventura)	Complete	09/30/2019	Yes
FSP Draft Report	In-Progress	10/28/19	No
FSP Final Report	Not Started	12/31/19	No

The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/19 - 12/31/19

Total Contract Amount: $400,143

Total Spent: $341,718

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/19	No
Data Management Support Services	In-Progress	06/30/20	Yes

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (18MHSOAC040)

MHSOAC Staff: Dawnte Early

Active Dates: 07/01/19 - 06/30/21

Total Contract Amount: $1,161,008

Total Spent: $290,252

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Report	Complete	09/30/19	Yes
Quarterly Progress Report	Complete	12/31/19	Yes
Quarterly Progress Report	Not Started	03/31/2020	No
Quarterly Progress Report	Not Started	06/30/2020	No
Quarterly Progress Report	Not Started	09/30/2020	No
Quarterly Progress Report	Not Started	12/31/2020	No
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

The iFish Group: Hosting & Managed Services (19MHSOAC022)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/20 - 12/31/20

Total Contract Amount: $305,143

Total Spent: $290,004

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/20	No
Data Management Support Services	In-Progress	12/31/20	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
JANUARY 2020

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	3	15	**18**
Participating Counties (unduplicated)	2	9	**11**
Dollars Requested	$3,981,963	$34,906,392	**$38,888,355**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2014-2015	N/A	26	$128,853,402	16 (27%)
FY 2015-2016	N/A	23	$52,534,133	15 (25%)
FY 2016-2017	33	30	$68,634,435	18 (31%)
FY 2017-2018	34	31	$149,219,320	19 (32%)
FY 2018-2019	53	53	$303,143,420	32 (54%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2019-2020	9	9	$15,164,623	8 (14%)

Total number of counties that have presented an INN Project since 2013:	Average Time from Final Proposal Submission to Commission Deliberation†:
56 (95%)	52 days

† This excludes extensions of previously approved projects, Tech Suite additions, and government holidays.

FY: Fiscal Year (July 1st – June 30th)

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Stanislaus	Whole Health Approach to Improve Mental Health Outcomes	$3,519,000	5 Years	8/28/2019	Pending
Under Review	San Mateo	Preventing Homelessness to Economic and Emotionally Stressed Older Adults	$750,000	3.9 Years	9/30/2019	Pending
Under Review	San Mateo	Addiction medicine Fellowship in a Community Hospital	$591,650	3.9 Years	10/2/2019	Pending
Under Review	San Mateo	Co-location of Prevention & Early Intervention Services in Low Income Housing	$925,000	3.9 Years	10/2/2019	Pending
Under Review	San Mateo	PIONEERS (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve)	$925,000	3.9 Years	10/2/2019	Pending
Under Review	San Mateo	Cultural Arts and Wellness Social Enterprise Café for Filipino/a/x Youth	$2,625,000	5 Years	10/2/2019	Pending
Under Review	Mendocino	Healthy Living Community	$2,197,718	5 Years	10/16/2019	Pending
Under Review	Sonoma	Using Cognitive Technologies to Create Client Care Plans	$992,428		11/13/2019	Pending
Under Review	San Bernardino	Eating Disorder Collaborative	$11,653,185	5 Years	11/7/2019	Pending
Under Review	San Bernardino	Cracked Eggs	$1.568,143	5 Years	11/27/2019	Pending
Under Review	Santa Clara	TECH SUITE for Community Health	$6,000,000	3 Years	11/27/2019	Pending
Under Review	Sacramento	Multi-County FSP Project	$500,000	4.5 Years	11/27/2019	Pending
Under Review	San Bernardino	Multi-County FSP Project	$979,634	4.5 Years	11/27/2019	Pending
Under Review	Siskiyou	Multi-County FSP Project	$700,000	4.5 Years	11/27/2019	Pending

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Ventura	Multi-County FSP Project	$979,634	4.5 Years	11/27/2019	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	El Dorado	Community HUBS Project EXTENSION	$2,158,704	1 Year	4/30/2019	11/4/2019
Under Final Review	El Dorado	Senior Health & Nutrition	$900,000	2 Years	4/30/2019	10/30/2019
Under Final Review	Stanislaus	NAMI On Campus High School	$923,259	5 Years	8/28/2019	12/30/2019

APPROVED PROJECTS (FY 19-20)			
County	Project Name	Funding Amount	Approval Date
Siskiyou	Integrated Care Project (extension)	$518,180	August 2019
Alameda	Supportive Housing Community Land Trust	$6,171,599	August 2019
Sutter-Yuba	iCARE (Innovative & Consistent Application of Resources and Engagement)	$5,228,688	September 2019
Glenn	Crisis Response and Community Connections	$787,535	September 2019
San Francisco	Addressing Socially Isolated Older Adults-EXTENSION	$195,787	October 2019
San Luis Obispo	Holistic Adolescent Health	$660,000	October 2019
San Luis Obispo	San Luis Obispo-Threat Assessment Program	$879,930.40	October 2019
Napa	Statewide Early Psychosis Learning Health Care Network	$258,480	November 2019

Butte	Physician Committed-EXTENSION	$464,424	November 2019

Calendar of Tentative Commission Meeting Agenda Items

Proposed 12/19/19

Agenda items and meeting locations are subject to change

February 27, 2020: Fresno, CA

Award Stakeholder Contracts
The Commission will consider awarding contracts to the highest scoring proposals received in response to the six Request for Proposals for stakeholder advocacy on behave of the six populations.

Early Psychosis Intervention Outline for Request for Proposal
The Commission will consider approval of an outline for the Early Psychosis Intervention Request for Proposals.

Draft School-Based Mental Health Services for Children Report
The Commission will be presented with the draft School-Based Mental Health Services Report.

Fiscal Transparency Tool Update and Demonstration of Criminal Justice Data Dashboard
The Commission will be presented with the updated Programs, Providers, and Services Transparency Tool and a demonstration of the new MHSA Transparency Suite Criminal Justice Dashboard.

MHSOAC Rules of Procedure Second Read (Tenatative, if needed)
The Commission will consider adoption of the proposed amendments to the Commission's Rules of Procedures.

Use of County Innovation Funds
Commission staff will provide an overview of county uses of Innovation funds outside of Innovation approval.

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2020
The Commission will consider legislative and budget priorities for the current legislative session.

Executive Director Report Out
Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 12/19/19

Agenda items and meeting locations are subject to change

March 26, 2020: Bay Area

Prevention and Early Intervention Project Panel

The Commission is working to identify prevention and early intervention priorities, data monitoring, and technical assistance as directed by Senate Bill 1004 (Wiener, 2018). This first public hearing for this project will explore opportunities for mental health promotion and mental health needs prevention.

Award Mental Health Student Services Act Contracts (Round 1)

The Commission will consider awarding contracts to the highest scoring proposals received in response to the Request for Proposals for the Mental Health Student Services Act.

Potential Innovation Plan Approval

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2020

The Commission will consider legislative and budget priorities for the current legislative session.

Executive Director Report Out

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

April 23, 2020: Anaheim, CA

Award Youth Drop-In Center Contracts

The Commission will consider awarding contracts in response to the Request for Proposals for the Youth Drop-In Centers.

Innovation Incubator Workplan

The Commission will be presented with a workplan and request contract approval for $2.5 million allocated in fiscal year 2019-20 for the Innovation Incubator relating to the justice involved population.

Potential Innovation Plan Approval

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2020

The Commission will consider legislative and budget priorities for the current legislative session.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 12/19/19

Agenda items and meeting locations are subject to change

Mental Health in the Workplace Panels

The Commission is exploring opportunities to support workplace mental health. This first public hearing for this project is intended to support the Commission's understanding of challenges related to workplace mental health, approaches that employers have used to support employees.

Executive Director Report Out

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

May 28, 2020: Los Angeles

Award Early Psychosis Intervention Contracts

The Commission will consider awarding contracts in response to the Request for Proposals for the Early Psychosis Intervention Program.

Governor's May 2020 Budget Revise Briefing and the Commission's 2020-21 Budget

The Commission will be presented with an overview of the Governor's May Budget Revise for Fiscal Year 2020-21. The Commission will consider approval of its final Fiscal Year 2019-20 Operations Budget and its proposed Fiscal Year 2020-21 Operations Budget.

Potential Innovation Plan Approval

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2020

The Commission will consider legislative and budget priorities for the current legislative session.

Executive Director Report Out

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

June 11, 2020: Sacramento, CA (Teleconference)

Award Mental Health Student Services Act Contracts (Round 2)

The Commission will consider awarding contracts in response to the Request for Proposals for the Mental Health Student Services Act.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 12/19/19

Agenda items and meeting locations are subject to change

July 23, 2020: TBD

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Prevention and Early Intervention Project Panel
The Commission is working to identify prevention and early intervention priorities, data monitoring, and technical assistance as directed by Senate Bill 1004 (Wiener, 2018). Commissioners will hear presentations from subject matter experts on opportunities to intervene early in the development of mental health needs, as well as the prevention of factors that may result in mental health needs.

Legislative Priorities for 2020
The Commission will consider legislative and budget priorities for the current legislative session.

Executive Director Report Out
Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

August 27, 2020: TBD

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2020
The Commission will consider legislative and budget priorities for the current legislative session.

Mental Health in the Workplace Panels
This second public hearing on the Mental Health in the Workplace project will explore research and policy recommendations to support voluntary workplace mental health standards. Panelists will provide testimony on strategies and models in the US and internationally to support workplace mental health.

Executive Director Report Out
Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

Agenda Item 5: DHCS Status Chart of County RERs Received
January 23, 2020 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated January 14th, 2020. This Status Report covers the FY 2016-17 through FY 2018-19 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review. FY 2017-18 RER data has not yet been incorporated into the Fiscal Reporting Tool due to format changes.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at https://mhsoac.ca.gov/resources/documents-and-reports/documents?field_county_value=All&field_component_target_id=46&year=all

On October 1, 2019, DHCS published a report detailing MHSA funds subject to reversion as of July 1, 2018, covering allocation year FY 2015-16 for large counties and 2008-09 for WET and CFTN funds, updating a July 1, 2018 report detailing funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). Both reports can be accessed at the following webpage:

https://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx

DCHS MHSA Annual Revenue and Expenditure Report Status Update

FY 2005-06 through FY 2016-17, all Counties are current

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Alameda	3/25/2019	3/26/2019	4/9/2019	12/31/2019	1/2/2020	1/6/2020
Alpine	5/10/2019	5/13/2019	5/15/2019			
Amador	12/19/2018	12/19/2018	12/21/2018	12/20/2019	12/24/2019	
Berkeley City	12/28/2018	1/2/2019	1/8/2019			
Butte	6/26/2019		6/26/2019	1/6/2020	1/7/2020	
Calaveras	1/10/2019		1/11/2019	12/30/2019	1/2/2020	1/2/2020
Colusa	3/28/2019	4/25/2019	4/30/2019			
Contra Costa	12/31/2018	1/7/2019	1/22/2019	1/6/2020	1/6/2020	1/10/2020
Del Norte	12/31/2018		1/2/2019	12/31/2019	1/2/2020	
El Dorado	12/28/2018	1/3/2019	1/25/2019	12/31/2019	1/2/2020	1/3/2020
Fresno	12/28/2018	1/2/2019	1/2/2019	12/30/2019	1/2/2020	
Glenn	12/31/2018	1/7/2019	2/11/2019	12/23/2019	n/a	12/26/2019
Humboldt	12/20/2018	12/21/2018	1/2/2019	1/6/2020	1/6/2020	
Imperial	12/26/2018		1/2/2019	12/9/2019	12/13/2019	12/18/2019
Inyo	3/19/2019	3/20/2019	3/22/2019			
Kern	1/4/2019		1/7/2019	12/19/2019	12/24/2019	
Kings	1/31/2019	2/4/2019	2/11/2019	1/6/2020	1/7/2020	
Lake	7/12/2019		7/16/2019	1/13/2020	1/14/2020	
Lassen	1/8/2019	1/14/2019	1/31/2019	12/30/2019	1/2/2020	
Los Angeles	12/31/2018	1/14/2019	1/29/2019			

Agenda Item 5: DHCS Status Chart of County RERs Received
January 23, 2020 Commission Meeting

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Madera	12/31/2018	1/7/2019	2/4/2019	1/7/2020	1/7/2020	
Marin	12/21/2018	12/21/2018	12/21/2018	12/23/2019	12/24/2019	12/26/2019
Mariposa	12/20/2018	1/3/2019	1/31/2019	12/19/2019	12/23/2019	
Mendocino	12/31/2018		1/3/2019	12/30/2019	1/2/2020	1/9/2020
Merced	12/21/2018	12/21/2018	12/31/2018	12/17/2019	12/23/2019	12/26/2019
Modoc	1/16/2019	1/16/2019	1/24/2019			
Mono	12/28/2018	1/3/2019	1/17/2019	12/27/2019	12/31/2019	1/3/2020
Monterey	3/5/2019	3/6/2019	9/4/2019	12/23/2019	12/26/2019	1/8/2020
Napa	12/28/2018	1/2/2019	1/4/2019	12/20/2019	12/26/2019	1/2/2020
Nevada	12/21/2018		12/21/2018	12/31/2019	n/a	1/3/2020
Orange	12/28/2018	1/2/2019	1/31/2019	12/27/2019	12/31/2019	12/31/2019
Placer	1/18/2019		1/22/2019			
Plumas	9/16/2019	9/17/2019	10/4/2019			
Riverside	12/31/2018		1/29/2019	12/31/2019	1/3/2020	
Sacramento	12/31/2018	1/2/2019	1/2/2019	12/27/2019	12/30/2019	1/13/2020
San Benito	3/8/2019	3/8/2019	3/18/2019			
San Bernardino	12/31/2018		1/2/2019	12/30/2019	12/31/2019	
San Diego	12/26/2018		1/15/2019	12/31/2019	1/6/2020	
San Francisco	12/31/2018	1/3/2019	1/30/2019	12/31/2019	1/3/2020	1/7/2020
San Joaquin	12/31/2018		1/7/2019	1/7/2020	1/10/2020	
San Luis Obispo	12/14/2018	12/18/2018	12/28/2018	12/30/2019	12/31/2019	
San Mateo	12/31/2018		1/2/2019	12/24/2019	12/30/2019	

Agenda Item 5: DHCS Status Chart of County RERs Received
January 23, 2020 Commission Meeting

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Santa Barbara	12/21/2018	1/3/2019	1/14/2019	12/20/2019	12/26/2019	
Santa Clara	12/27/2018		1/2/2019	12/13/2019	12/16/2019	12/31/2019
Santa Cruz	12/31/2018	1/3/2019	1/7/2019	1/2/2020	1/7/2020	
Shasta	12/13/2018	12/17/2018	1/2/2019	12/18/2019	12/23/2019	12/30/2019
Sierra	12/28/2018		1/2/2019	12/19/2019	12/26/2019	
Siskiyou	9/3/2019	9/3/2019	9/24/2019			
Solano	12/31/2018	1/3/2019	2/21/2019	12/30/2019	1/2/2020	
Sonoma	1/16/2019	1/29/2019	2/1/2019	12/18/2019	12/26/2019	
Stanislaus	12/26/2018		1/3/2019	12/31/2019	1/3/2020	1/3/2020
Sutter-Yuba	1/7/2019	1/28/2019	1/31/2019	1/2/2020	1/6/2020	
Tehama	6/20/2019		8/12/2019			
Tri-City	12/31/2018	1/3/2019	1/30/2019	12/30/2019	12/31/2019	
Trinity	1/30/2019		2/7/2019			
Tulare	12/19/2018	12/21/2018	12/26/2018	12/19/2019	12/23/2019	12/23/2019
Tuolumne	12/11/2018	12/12/2018	12/12/2018	10/21/2019	10/23/2019	10/25/2019
Ventura	12/20/2018		12/21/2018	1/13/2020		
Yolo	1/30/2019	1/31/2019	1/31/2019	12/20/2019	12/24/2019	1/3/2020
Total	59	39	59	47	44	22

AGENDA ITEM 6

Action

January 23, 2020 Commission Meeting

Amendment to the MHSOAC Rules of Procedure

Summary: The Commission will consider adoption of the proposed amendments to the Commission's Rules of Procedure.

The Commission's strategic planning process highlighted the need and opportunity to amend the Rules of Procedure, which were originally adopted in 2009 and last amended in March of 2016. In drafting the proposed amendments, staff reviewed rules from other boards and commissions in addition to documenting current Commission practices.

Most of the proposed amendments are non-substantive and/or reflect current Commission practices. The enclosed draft of the proposed amendments shows new language in underlined text and deleted language in strikethrough text. Below is a brief summary of the proposed substantive changes.

- Mission Statement
  The Mission Statement is changed to be consistent with the language in the Commission's proposed Strategic Plan.

- Rule 1.1 Terms of Commissioners
  Paragraph A adds language regarding the Commission's composition as set forth in Welfare and Institutions Code Section 5845.

  Paragraph B inserts new language to clarify the process for Commissioners to communicate their intention to resign or to serve until reappointed or replaced, and deletes language inconsistent with the three-year term prescribed in Welfare and Institutions Code Section 5845.

- Rule 1.7 Training and Orientation
  Paragraph B is revised to replace a specified long list of documents to be provided to a Commissioner upon appointment with a shorter list of documents and a provision to provide any document that may be helpful to fulfill the Commissioner's responsibilities.

  Paragraph C adds to the list of training the recent statutory requirement for sexual harassment and abusive conduct prevention training specified in Government Code Section 12950.1.

- Rule 1.9 Conflict of Interest
  Eliminates a provision to adopt an Incompatible Activities Policy. Upon appointment by the Governor, Commissioners are required to sign an Incompatible Activities Policy and thus the provision to adopt such a policy was deleted as duplicative.

- Rule 2.1 Duties of the Executive Director
  The revisions to Rule 2.1 consolidates the current listed duties and adds a provision that the Executive Director is to fulfill the responsibilities in the Executive Director's duty statement and implement the duties delegated in the Rules of Procedure. Paragraph C adds the current practice of presenting the budget and expenditure to the Commission.

- Rule 2.2 Designation of Acting Executive Director
  The revision adds a requirement that the Executive Director notify the Chair and Vice Chair when the Executive Director delegates any duties set forth in the Rules of Procedure.

- Rule 2.4 Contract Authority of the Executive Director
  The amendment proposes to double the delegated authority to $200,000 for regular contracts and $400,000 for interagency agreements, respectively, consistent with the Department of General Services doubling of the delegated authority for State departments. The current delegated contract authority was adopted by the Commission 9 years ago and is limited to $100,000 or less for regular contracts and $200,000 or less for interagency agreements.

  Paragraph B further authorizes the Executive Director, with the consent of the Chair and Vice Chair, to enter into contracts in the amount of $500,000 or less for regular contracts and $750,000 or less for interagency agreements. This higher threshold for delegated contract authority is supported by the additional layer of accountability and transparency incorporated into new Rule 2.1C, which requires the Executive Director to present the budget and expenditure to the Commission three times a year: beginning of the fiscal year for adoption, a mid-year expenditure report, and a close-of-year expenditure report.

- Rule 2.5 Authority of the Executive Director to Advocate on Legislation
  Paragraph A is added to reflect the Commission's authority under the Mental Health Services Act.

  Paragraph B modifies the current authority so that it is more specific. The revised rule provides that the Executive Director is authorized on behalf of the Commission to advocate on legislation when the legislation advances a formally established position of the Commission; or (2) when the legislation advances an informal or emerging position of the Commission as affirmed through consultation with the Chair and Vice Chair.

  Paragraph C is revised to be consistent with the requirement that state budget proposals are confidential until made public by the Governor or Legislature.

- Rule 2.6 Authority to Approve Innovation Projects
  The current rule is replaced with the authority to approve Innovation projects as delegated to the Executive Director at the May 23, 2019 Commission meeting.

- Rule 4.11 Quorum
  The revisions are consistent with an Attorney General's opinion that provides that a quorum is a majority of the membership (including vacancies) and that a majority of the quorum may act to bind the Commission. The changes clarify that the meeting may continue in the absence of a quorum, but the Commission may not take action without the presence of a quorum and that actions require the support of not less than five voting members.

- Rule 4.12 Voting
  Paragraph D is revised to specify that adoption of policy project reports requires either first and second reads at separate Commission meetings or a recommendation for approval from a Commission subcommittee. The rationale for the first read/second read requirement, adopted in 2009, was to provide the public sufficient time to review and provide feedback to the Commission. In the last ten years since this rule was adopted the Commission has established a process for extensive community engagement, public hearings, and opportunities for input on its policy projects. As such, the first read/second read requirement is revised to better address the original intent.

- Rule 5.1 Public Outreach and Engagement
  New Rule 5.1 on Public Outreach and Engagement specifies how the Commission will carry out its commitment to ensuring the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in the Commission's decisions and recommendations.

- Rule 6.1 Committee Structure
  Paragraph A replaces the requirement (i.e. "shall") for the Commission to have committees with the authority (i.e. "may") consistent with the Welfare and Institutions Code 5845(d)(3). In addition, the rule clarifies that committees do not have authority to make decisions on behalf of the Commission unless given explicit and written delegated authority.

  Paragraph A.1. clarifies that the Committee chair and vice chairs assume their duties immediately upon appointment by the Commission chair instead of in January following the appointment.

  Paragraph A.2. modifies the public membership of committees to: (a) change the term of the committee members from two years to one year to coincide with the term of the committee chair and vice chair; (b) balance the desire to have consumers, family members, and members of underserved ethnic and cultural communities with the needed expertise to support the committee's goals. The new language requires the committee chair and vice chair in appointing committee members to seek individuals with the desired expertise who are consumers, family members, and members of underserved ethnic and cultural communities. This new membership structure would

replace the current requirement for each committee to 2 consumers, 2 family members, and 2 members of underserved ethnic and cultural communities.

Paragraph B explicitly provides the Commission may establish any multi-member body consisting of Commissioners only as necessary to support the Commission's work.

Enclosures (1): Rules of Procedure with proposed January 2020 amendments.

Handouts: A PowerPoint presentation will be provided at the meeting.

RULES OF PROCEDURE

Proposed January 2020 amendments

(New language is shown in underlined text and deleted language is shown in strikethrough text.)

MHSOAC

Mental Health Services
Oversight and Accountability Commission

TABLE OF CONTENTS

To be added when document is completed.

MISSION

The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care.

~~The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system.~~

GOVERNANCE PHILOSOPHY

Integrity and sound stewardship are paramount in the governance of all Commission activities. The Commission ~~MHSOAC~~ will govern itself with an emphasis on the following:

a.) ~~Being~~ Advancing an objective understanding and incorporating diverse ~~diversity in~~ viewpoints;
b.) Making decisions in a transparent, responsive ~~an efficient~~ and timely manner;
c.) Striving to improve ~~for~~ results and outcomes;
d.) Elevating transformative ~~Focusing on outward~~ vision and strategic leadership ~~and less on administrative detail~~;
e.) Working ~~Using~~ collaboratively to drive system-scale improvements ~~rather than individual decisions-making processes~~;
f.) Being proactive ~~rather than reactive~~

~~Specifically~~:

~~a. The MHSOAC will cultivate a sense of group responsibility. The MHSOAC will be responsible for excellence in governing. The MHSOAC will use the expertise of individual members to enhance the ability of the MHSOAC.~~

~~b. The MHSOAC will direct evaluate, and inspire the organization through the careful establishing written policies, procedures and directives.~~

~~c. The MHSOAC will enforce upon itself the necessary discipline to govern with excellence, including preparation and regular attendance at meetings, thorough preparation by each member for each meeting, adherence to its policymaking principles, and respecting the roles.~~

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~~d. Continual development of the MHSOAC will include orientating of new members in the Commission's governance policies and processes, periodic re-orientation of existing members, and regular discussion of process improvement~~.

~~e. The MHSOAC will regularly discuss and evaluate its performance and take steps to improve its effectiveness~~.

COMMISSIONERS

1.1 Terms of Commissioners

A. The Commission consists of 16 voting members: the Attorney General or designee; the Superintendent of Public Instructions or designee; the Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate; the Chairperson of the Assembly Committee on Health or another member of the Assembly selected by the Speaker of the Assembly; and twelve members appointed by the Governor to specified seats: two individuals with lived experiences, two family members, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer. (Welfare and Institutions Code Section 5845)

B. ~~Pursuant to Welfare and Institutions Code Section 5845,~~ The term of each Commissioner ~~member shall be~~ is three years, to be staggered so that approximately one-third of the appointments expire in each year. A Commissioner may resign prior to the end of the Commissioner's term by submitting written notification to the appointing authority and sending a copy of the resignation to the Commission Chair and the Executive Director. A Commissioner who desires to serve after their term has expired shall notify the Commission Chair and the Executive Director in writing of their intention to serve until reappointed or replaced by a new appointee. ~~Members shall~~ Commissioners serve without compensation but ~~shall be~~ are reimbursed in accordance with the policy of the State of California for all actual and necessary expenses incurred in the performance of their duties. (Welfare and Institutions Code Section 5845)

~~If a Commissioner cannot attend a Commission meeting he or she will notify the Chair and the Executive Director of such absence in advance of the Commission meeting. If a Commissioner misses one (1) Commission meeting without notice or three (3) Commission meetings in a calendar year with notice the Chair shall notify the Commissioner and that Commissioner's appointing power in writing that the attendance record of the Commissioner be improved or that the Commissioner be replaced.~~

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1.2 The Role of Commissioners

A. Commissioners are expected to work collectively to accomplish the Commission's goals as adopted by the Commission and to attend Commission meetings in person or via teleconference.

B. At the request of the Chair, Commissioners are expected to serve as a member of a committee, subcommittee, or other Commission body.

C. At the request of the Chair, Commissioners are expected to represent the Commission in meetings, conferences, testimony in public hearings, and other speaking engagements.

D. The Commissioner with the most seniority and present at the meeting is expected to preside at the Commission meeting when neither the Chair nor Vice Chair is available to run all or part of the meeting.

- ~~Represent the MHSOAC outside Commission meetings~~
- ~~Provide knowledge and expertise to guide Commission policy-making~~
- ~~Attend Commission meetings throughout the state~~
- ~~Serve as a member of at least one MHSOAC Committee~~
- ~~Attend, in person or via teleconference, meetings of any MHSOAC Committee of which they are a member~~
- ~~Work collectively to accomplish the goals of the MHSOAC as set forth in its Multi-Year Strategic Plan and/or the yearly Work Plan~~

~~The best decisions come out of unpressured collegial deliberations and the MHSOAC seeks to maintain an atmosphere where the Commission or Committee members can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the MHSOAC encourages members to come to meetings without having fixed or committed their positions in advance.~~

1.3 Chair

A. Election of the Chair

A.1. The Commission shall elect a Chair ~~shall be elected~~ at a ~~MHSOAC~~ Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Chair shall be elected by a majority of the Commissioners present and voting consistent with the Rule 4.11A ~~members of the MHSOAC~~ and shall assume all duties ~~and presides at all MHSOAC meetings~~ starting January 1, following ~~January~~ the election. The Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Chair. ~~The term of the Chair shall be one year each~~.

A.2. In the event more than two candidates are nominated for Chair and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Chair

B.1. The Chair, with input from Commissioners and staff, sets the Commission's meeting agenda, prioritizing and scheduling agenda items as appropriate, and conducts the meetings.

B.2. The Chair appoints Commissioners to Commission subcommittees, committees, or other bodies as necessary to conduct the Commission's business.

B.3. The Chair provides guidance and direction to the Executive Director on Commission business, including but not limited to: (a) advocating on legislation consistent with Commission Rule 2.5; (b) approving Innovation projects consistent with Commission Rule 2.6; and (c) placing items on the Commission agenda consistent with Commission Rule 4.5.

B.4. In the event the Chair is unable to continue with the Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, ~~of the Chair~~ the Vice Chair shall assume all of the responsibilities of the Chair until a successor is elected. The election shall be held within 60 days of the vacancy ~~after resignation, death~~.

1.4 Vice Chair

A. Election of the Vice Chair

A.1. The Commission shall elect the Vice Chair ~~shall be elected~~ at a ~~MHSOAC~~ Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Vice Chair shall be elected by a majority of the Commissioners present and voting consistent with the Rule 4.11A ~~members of the MHSOAC~~ and shall assume all duties ~~and presides at all MHSOAC meetings~~ starting January 1, following ~~January~~ the election. The Vice Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Vice Chair.

A.2. In the event more than two candidates are nominated for Vice Chair, and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Vice Chair

B.1. The Vice Chair fulfills the role of Chair and presides at meetings in the absence of the Chair.

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B.2. In the event the Vice Chair is unable to continue with the Vice Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, an election for a successor shall be held within 60 days of the vacancy.

B.3. When neither the Chair nor Vice Chair is available to run all or part of the meeting, e.g., both officers may be absent, need to leave the room, or are disqualified from discussion and action on an item due to conflict of interest, the ~~most senior~~ Commissioner with the most seniority on the Commission who is present shall preside at the meeting.

1.5 Commission Member Vacancy

~~Commissioners may leave office at the end of their term or sooner.~~ When a vacancy occurs on the Commission, a successor is selected by the appointing authority ~~power~~.

1.6 Compensation and Expenses

Commissioners, ~~staff, agendized presenters, and active Committee members~~ will be reimbursed in accordance with State per diem laws. Also, any reasonable business expenses incurred will be reimbursed as authorized by law ~~the Commission~~. ~~On a case-by-case basis the designee of a Committee member may also be reimbursed in accordance with the State per diem laws.~~

1.7 Training and Orientation

A. New Commissioners ~~members~~ shall within 30 days of being appointed receive ~~training and~~ orientation in: (1) Commission governance, policies and procedures; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues; and (4) relevant laws and statutes.

B. At or before the orientation session, the new Commissioner ~~member~~ will receive the following documents:

1) The Bagley-Keene Open Meeting Act

2) Information on the Political Reform Act and how it affects Commissioners

3) The Commission's Conflict of Interest Code

4) The Commission's Rules of Procedure

5) List of Commission meeting dates and locations

6) Any other documents that may be helpful to the Commissioner to fulfill the Commissioner's responsibilities on the Commission

~~1) Listing of names, addresses, and contact information for the Commission members;~~

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~~2) Listing of names and contact information for MHSOAC Staff~~

~~3) Copy of the Rules of Procedure~~

~~4) Brief history and overview of MHSOAC including mission, purpose statement, and Proposition 63~~

~~5) Information about the Political Reform Act and how it affects the Commissioners~~

~~6) Information about the travel reimbursement procedures~~

~~7) List of meeting dates and locations~~

~~8) Copy of the Bagley-Keene Open Meeting Act~~

~~9) Summary of Robert's Rules of Order~~

~~10) Copy of the following documents:~~

~~a) Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction;~~

~~b) Recommendation to the MHSOAC for funding for Innovative Programs;~~

~~c) Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities;~~

~~d) Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders;~~

~~e) Mental Health Services Oversight and Accountability Commission Position Paper on Training and Education;~~

~~f) Any other policy paper adopted by the Commission~~

C. As required by Government Code Sections 11146 through 11146.4 and 12950.1, within six months of beginning service as a ~~member of the~~ Commissioner and at least every two years thereafter, ~~members of the~~ Commissioners shall receive training on laws related to ethics, conflict of interest requirements, governmental transparency, open government, ~~and~~ fair government processes, and sexual harassment and abusive conduct prevention.

1.8 Statement of Economic Interest – Form 700

Each Commissioner is required by the California Political Reform Act and the corresponding regulations to file a Statement of Economic Interests, Form 700: (1) within 30 days of being appointed; (2) on a yearly basis as prescribed by law; and (3) within 30 days of ending Commission membership.

1.9 Conflict of Interest

A. Presence of a conflict of interest prohibits Commissioners ~~(~~as public officials~~)~~ from participating in discussion about or taking action on an item. Provisions in California statutes, regulations, and case law define and provide guidelines related to conflict of

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interest. A Commissioner shall not make, participate in making, or in any way attempt to use ~~his or her~~ the Commissioner's official position to influence a Commission decision in which ~~he or she~~ the Commissioner knows or has reason to know ~~he or she~~ the Commissioner has a financial interest (Government Code Section 87100). Additionally, Commissioners must be guided solely by the public interest, rather than by personal interest, when dealing with contracting in an official capacity (Government Code Section 1090 et seq.).

B. A Commissioner who has a financial conflict of interest shall ~~must~~ do the following:

1) Notify the Executive Director as soon as possible if any agenda item presents a potential conflict of interest. This will prepare the Chair to announce the Commissioner's nonparticipation in any discussion, deliberation or vote when the item comes up.
2) Publicly identify, in enough detail to be understood by the public, the financial interest that causes the conflict of interest or potential conflict of interest.
3) Recuse ~~himself or herself~~ themselves from discussing or voting on the matter or from attempting to use ~~his or her~~ their position to influence the decision.

~~The Commission will adopt for itself and adhere to an Incompatible Activities Policy.~~

1.10 Commission Representation

A. Every Commissioner ~~member of the MHSOAC has~~ retains the right to express ~~his or her~~ their opinion on any subject whenever the ~~member~~ Commissioner is acting as an individual and not on behalf of ~~or at the expense of~~ the Commission.

B. Commissioners who agree to represent the Commission ~~in meetings, conferences, testimony in public hearings, speaking engagement, etc,~~ and do so at the request of the Commission, ~~with or without reimbursement,~~ agree ~~also~~ to represent only the officially approved positions of the Commission or a complete and accurate presentation of issues under consideration by the Commission. Commissioners whose personal positions are in conflict with the Commission's official positions must represent either the Commission's positions only or decline the request to represent the Commission.

C. A Commissioner is considered to be acting officially on behalf of the Commission whenever ~~he or she~~ the Commissioner states or implies that ~~he or she is~~ they are acting as a representative or member of the Commission, whenever the ~~member~~ Commissioner is authorized by the Commission to represent it, or the activity of the ~~member~~ Commissioner results in an expense~~, direct or indirect~~ to the Commission. ~~Examples of such expenses include but are not limited to compensation for travel, per diem, phone calls, postage, use of Commission stationary, or other materials produced or furnished by the Commission~~.

D. Nothing shall prevent ~~members of the~~ Commissioners from expressing their views as individuals in ~~regular or special meetings of the~~ Commission meetings or activities when these views bear directly upon policy issues under discussion.

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EXECUTIVE DIRECTOR

2.1 Duties of the Executive Director

A. The Executive Director is appointed and discharged by the Commission ~~MHSOAC~~. The Executive Director acts under the authority of, and in accordance with direction from the Commission ~~MHSOAC~~. ~~Commissioners should direct their requests for information or assistance from staff to the Executive Director.~~

B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state and local agencies, national and international organizations, private sector leaders, and other stakeholders.

~~The Executive Director also serves as the Commission's liaison with, county commissions, other mental health associations and stakeholder groups~~.

C. The Executive Director presents to the Commission the annual budget and expenditures at the beginning of the fiscal year for Commission adoption, a mid-year expenditure report, and a close-of-year expenditure report.

D. The Executive Director fulfills the responsibilities set forth in the Executive Director's duty statement and implements the delegated authority specified in the Rules of Procedure.

~~a) Achieving the results set forth in the Multi-Year Strategic Plan of the MHSOAC within the appropriate and ethical standards of business conduct set by the Commission and the State of California;~~

~~b) Plan, organize, direct, and administer all activities, programs and functions of the MHSOAC;~~

~~c) Respond to direction from the Chair to develop ideas for programs and/or initiatives reflecting the MHSOAC's goals.~~

~~d) Direct the preparation of all reports to be submitted by the MHSOAC to the Governor and Legislature;~~

~~e) Direct the preparation of the MHSOAC's annual budget for review by the Chair and submission to the Department of Finance, and/or the Legislative Analyst;~~

~~f) Direct the implementation of all federal and state statutes and regulations and Commission policies that require action by staff, administer the civil service system (including hiring, evaluating and terminating all employees), attend meetings of the Commission and report on the general affairs of the Commission, and keep the Commission advised as to the needs of the MHSOAC.~~

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2.2 Designation of Acting Executive Director

When the Executive Director is absent or otherwise unavailable to perform the duties set forth in these Rules of Procedure ~~of the office~~, the Executive Director may designate in writing another person to act on the Executive Director's behalf. Within 24 hours of such delegation the Executive Director shall notify the Chair and Vice Chair of the delegation including the scope and duration of the delegation.

2.3 Evaluation of Executive Director

The Commission shall in closed session evaluate the Executive Director's performance on an annual basis. Prior to the closed session evaluation, the Chair and Vice Chair will provide the Executive Director with a performance review to be discussed in the closed session evaluation. The evaluation will be based on the ~~MHSOAC's accomplishment of the Commission's Multi-Year Strategic Plan;~~ performance goals and professional development objectives adopted ~~annually~~ by the Commission and the Executive Director's duty statement ~~developed and adopted by the Commission~~.

2.4 Contract Authority. ~~Pursuant to the MHSOAC Resolution adopted on March 24, 2011,~~

A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf ~~of the MHSOAC~~ in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less. ~~The Executive Director may delegate to subordinates any of the authority delegated to the Executive Director by the MHSOAC. Within 24 hours of such delegation the Executive Director shall notify the MHSOAC Chair and Vice Chair~~.

B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $500,000 or less and to enter into Interagency Agreements in the amount of $750,000 or less.

2.5 Authority ~~of the Executive Director~~ to Advocate on Legislation.

A. The Commission is authorized to advise the Governor and Legislature regarding actions the State may take to improve the mental health care and services of Californians. As part of this authority, the Commission may advocate on legislation.

B. The Executive Director, or ~~his or her~~ the Executive Director's designee, is authorized on behalf of the ~~MHSOAC~~ Commission to advocate on legislation: (1) when the legislation ~~is consistent with~~ advances a formally established ~~an officially approved~~ position of the Commission; or (2) when the legislation advances an informal or emerging position of the Commission after consultation with the Chair and Vice Chair. ~~at the direction of the Chair and when the legislation furthers the interest of the Commission~~.

C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts.

2.6. Authority to Approve Innovation Projects.

A. The Executive Director, with the consent of the Commission Chair, is authorized to approve a county Innovation plan that meets any of the following conditions:

1) The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total MHSA Innovation spending authority of $1,000,000 or less.
2) The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director,
    a) differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review and are non-substantive, and
    b) the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

B. The Executive Director shall publicly report to the Commission, at the next Commission meeting ~~at the first available opportunity~~, any county Innovation plan approved by the Executive Director on behalf of the Commission under this delegated authority.

~~**2.6 Authority to Approve Additional Funding for Previously Approved Innovation Projects**~~

~~The Executive Director, or his or her designee, is authorized to approve a county's request to expend additional Mental Health Services funding in an amount not to exceed $500,000 or 15% of the total project, whichever is less, for an Innovation project that has been previously approved.~~

LEGAL COUNSEL

3.1 Duties of Chief Legal Counsel

A. Chief Counsel provides legal advice to the ~~MHSOAC~~ Commission and ~~The Chief Counsel~~ reports both to the ~~MHSOAC~~ Commission and to the Executive Director.

B. Chief Counsel is responsible for, among other things, advising staff regarding all relevant legal matters and supporting the legal inquiries and meeting activities of the ~~MHSOAC~~ Commission.

C. In situations where the Chief Counsel ~~would have~~ may have a conflict of interest, or where legal expertise outside the practice of Chief Counsel is imperative, the Commission may consult ~~consultation~~ with the office of the Attorney General or another state department. ~~via an interagency agreement is available.~~

D. Counsel shall not provide legal counsel to members of the Commission except in their role as members of the ~~MHSOAC~~ Commission.

3.2 Hiring Chief Counsel

A. The Executive Director is responsible for hiring and discharging the Chief Counsel.

B. The Executive Director is responsible for evaluating the Chief Counsel's performance with input from the ~~MHSOAC~~ Commission and staff.

COMMISSION MEETINGS

4.1 Frequency of Meetings

A. ~~MHSOAC~~ Commission meetings are to be held as often as is necessary to enable the Commission to fully and adequately perform its duties, but ~~it shall not meet~~ not less than once each quarter. ~~at any time and location convenient to the public as it may deem appropriate~~. All meetings shall be open to the public pursuant to the Bagley-Keene Open Meeting Act.

B. The ~~MHSOAC~~ Commission meeting schedule for the ~~following~~ calendar year is approved ~~prior to~~ in January of that calendar year.

4.2 Robert's Rules of Order

Robert's Rules of Order will be used as a guide at ~~the~~ Commission ~~and Committee~~ meetings.

4.3 Open Meetings

A. Commission meetings are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq.

~~The principal law that governs the meetings of the MHSOAC and its Committees is the Bagley-Keene Open Meeting Act which is set forth in Government Code Sections 11120 et seq.~~

~~4.4 Serial Meetings~~

B. The Bagley-Keene Open Meeting Act prohibits ~~the MHSOAC~~ Commissioners from using direct communication, personal intermediaries, or technological devices to discuss, deliberate, or take action outside of an open meeting (Government Code Section 11122.5 (b)). Serial meetings are also prohibited. A serial meeting is a series of communications, each of which involves less than a quorum of the Commission, but which taken as a whole involves a majority of the Commission's members. (Government Code Section 11122.5 ~~11121~~).

~~4.5~~ 4.4 Agenda Items

A. A Commission meeting agenda may include action or information items.

B. Action items that are non-controversial or pro forma may be placed on the consent calendar. All items on the consent calendar are voted upon as one unit and are not voted upon as an individual item. At the meeting any Commissioner may ask that a matter be removed from the consent agenda and that request shall be effective without further action. If a matter is removed from the consent agenda it ~~shall~~ may be discussed at ~~a point in~~ the same meeting or at a different Commission meeting as deemed appropriate by the Commission. There shall be no discussion or presentations made concerning items that remain on the consent agenda.

~~Information items consist of presentations made to Commissioners to give background to an issue, an update, or may be in response to a Commissioner's inquiry. Since all agenda items are subject to action by the Commission there may be information items upon which the Commission decides to take action.~~

~~Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions.~~

~~4.6~~ 4.5 Request for Item to be Placed on the Agenda

A. Agenda items are placed on the Commission's meeting agenda with the approval of the Chair and Executive Director. The final meeting agenda is approved by the Chair and the Executive Director after consultation with the Chief Counsel.

B. Individual Commissioners wishing to place items on the agenda should contact the Chair or the Executive Director.

C. Members of the public wishing to place items on the agenda should contact Commission staff.

~~Agenda items shall only be placed on the Commission's agenda at the request of (1) a Committee of the MHSOAC; (2) a member of the MHSOAC; or (3) MHSOAC staff with the approval of the Executive Director. Members of the public wishing to place items on the agenda must go through one of the above~~.

~~Before agenda and meeting packets are finalized, they shall be reviewed by the Chair of the Commission, the Executive Director, Chief Counsel. The Chair of the Commission, the Executive Director, and the Operations Committee shall work together to develop and set the Commission agendas~~.

~~4.7~~ 4.6 Exhibits and Handouts

A. Agendized presenters who are not associated with the Commission may provide exhibits and handouts related to their presentation for distribution at the Commission meeting and are encouraged to submit them to the Commission at least two weeks before the meeting.

Additionally, they are encouraged to provide the materials in an electronic format that meets federal and state accessibility standards.

B. The Commission will make the above-mentioned materials available to the public by publishing them on the Commission website in a format that meets federal and state accessibility standards. The Commission will also send a notice to the Commission's list-serve that the materials have been published on the website.

C. If the above-mentioned materials were received by the Commission within a reasonable time before the meeting date, the Commission will also make those materials available in printed format for public inspection on the day of the meeting.

~~Presenters may provide exhibits and handouts for distribution to the Commissioners. Presenters are encouraged to provide sixteen copies to the Commission office for distribution to the Commissioners and staff. Staff at least two weeks before the Commission meeting. Staff will post the material on the Commission website and notice of the posting will be emailed to the MHSOAC list-serve. The materials will also be made available to the public at the meeting.~~

~~4.8~~ 4.7 Public Agenda Notice ~~(PAN)~~

A. A public agenda notice of any Commission meeting must be ~~given and~~ made available on the Commission's website at www.MHSOAC.ca.gov, at least 10 calendar days before the meeting. The ~~PAN~~ public agenda notice will also be emailed to the ~~MHSOAC~~ Commission's list-serve. A copy of the public agenda notice will also be sent to any person who requests one in writing ~~it a PAN in writing must be sent a copy~~ (Government Code Section 11125).

B. The ~~PAN~~ public agenda notice of a Commission meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted (Government Code Section 11125).

C. The ~~PAN~~ public agenda notice of a Commission meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed in either open or closed session. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act (Government Code Section 11125).

D. ~~Upon request by a person with a disability the PAN~~ The public agenda notice of a Commission meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The ~~PAN~~ public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting (Government Code Section 11125).

~~4.9~~ 4.8 Availability of Commission Meeting Materials

A. ~~PANs~~ The public agenda notice and all other materials distributed to the Commissioners prior to or at a Commission meeting are public records and as such are subject to disclosure, unless a recognized exemption applies under California Public Records Act, set forth in Government Code Sections 6250 et seq. or the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. Commission meeting materials are available to the public at www.MHSOAC.ca.gov ~~as attachments to the PAN~~. The Commission will also make meeting materials ~~are also~~ available for public inspection in printed format on the day of the meeting.

B. The Bagley-Keene Open Meeting Act provides that unless a specific exemption applies, materials ~~writings~~ pertaining to agenda items ~~that are public records and have been~~ distributed to the Commission by the staff or individual Commissioners prior to or during the meeting must be made available for public inspection at the meeting. Materials pertaining to agenda items ~~or if~~ prepared by a ~~some~~ person other than staff or a Commissioner shall be made available after the meeting. In addition, the materials ~~writing~~ shall be distributed to all persons who request or have requested copies of the materials ~~writings~~ and will be ~~made~~ available on the ~~MHSOAC~~ Commission's website.

~~4.10~~ 4.9Closed Sessions

A. Any closed session must be noted on the meeting agenda and properly noticed, citing the statutory authority or provision of the Bagley-Keene Open Meeting Act that authorizes the ~~particular~~ closed session. The Commission may only hold closed sessions for the reasons set forth in the Bagley-Keene Open Meeting Act. ~~Pursuant to the Bagley-Keene Open Meeting Act, the following matters may be properly conducted in closed session:~~

- ~~To consider the appointment, employment, evaluation of performance, discipline or dismissal, as well as to hear charges or complaints about a Commission employee's actions (Government Code Section 11126(a)(1)).~~
- ~~To confer with or receive advice from legal counsel regarding pending litigation when discussion in open session would prejudice the Commission's position in the litigation (Government Code Section 11126(e)(1)).~~

B. Prior to convening a closed session, the Chair must publicly announce those issues that will be considered in closed session (Government Code Section 11126.3). This can be done by a reference to the item as properly listed on the agenda. After the closed session has been completed, the ~~MHSOAC~~ Commission must reconvene in public prior to adjournment (Government Code Section 11126.3). If the closed session involved a decision to hire or fire an individual the Chair is required to report the action taken, and any roll call vote taken.

C. Chief Counsel will attend each closed session and keep and enter in a minute book a record of topics discussed and decisions made at the meeting. These minutes are confidential, maintained ~~in a sealed envelope~~ by Chief Counsel, and are discoverable

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only to the Commission itself or to a reviewing court. The minutes may, but need not, consist of a recording of the closed session. (Government Code Section 11126.1)

~~4.11~~ 4.10 Teleconference Meetings

Pursuant to the Bagley-Keene Open Meeting Act ~~provides that~~ the ~~MHSOAC~~ Commission ~~or committees~~ may hold a meeting by audio or audio-visual teleconference for the benefit of the public and the Commission ~~or committee~~ (Government Code Section 11123). All ~~PAN~~ public agenda notice requirements apply.

~~4.12~~ 4.11Quorum

A. A simple majority of the Commission's statutory membership shall constitute a quorum for the transaction of business. The Commission's statutory membership is 16 members making nine members a quorum. A majority of the quorum (i.e. five members) may act to bind the Commission.

B. A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be taken in the absence of a quorum is to fix the time in which to adjourn, recess, or take measures to obtain a quorum.

~~Every act or decision done or made by a majority of the Commissioners present at the meeting duly held at which a quorum is present, shall be regarded as binding. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of Commissioners below a quorum, if any action taken is approved by at least a majority of the required quorum for the meeting.~~

~~4.13~~ 4.12Voting

A. After a motion is made, seconded, and public comment has been heard, the Commission may vote. A Commissioner must be present to vote.

B. A Commissioner ~~member~~ who is disqualified in a matter because of financial contributions, financial interest, or another conflict is not entitled to vote. The Commissioner is required to announce at the meeting that the Commissioner ~~he or she~~ "will not participate" and disclose the reasons for the disqualification on the record. This information is noted in the meeting minutes.

C. A Commissioner may "abstain" from voting, if the Commissioner ~~he or she~~ is entitled to participate but chooses not to. The reason for abstaining ~~not participating~~ need not be disclosed on the record.

D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report.

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~~Any proposed policy item on the agenda, along with its corresponding language/documents, shall be presented for discussion at a Commission meeting at least one (1) meeting prior to the meeting at which the vote on the issue is taken.~~

~~The Commission may take action, by a simple majority, on an agenda item at the same meeting that the item is presented if the Commission deems that there exists a need to take action.~~

~~Approval of county MHSA Innovation Plans is exempt from this review schedule and may be voted upon at the Commission meeting at which they are first presented by staff and need not be posted 30 days before the meeting.~~

~~4.14~~ 4.13Public Comment

A. Opportunity is provided for the public to address the Commission on agenda items. The Commission may adopt reasonable procedures so that members of the public have an opportunity to directly address the Commission on each agenda item before the Commission. These procedures may include limiting the total amount of time allocated for public comment on a specific agenda item ~~particular issues~~ and for each individual speaker. (Government Code Section 11125.7)

B. If the agenda item has already been considered by a subcommittee or committee composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the subcommittee or committee on the item, additional public comment opportunity at the Commission meeting need not be provided unless the item has been substantially changed since the subcommittee or committee heard the item. (Government Code Section 11125.7)

C. Members of the public who wish to provide public comment at a meeting are encouraged to complete a public comment card but are not required to do so. ~~The meeting coordinator will request anyone planning to speak to complete a public comment card~~.

~~It is the policy of the Commission to vet issues as much as is practical through the MHSOAC standing committees before those issues are brought to the full Commission. It is the responsibility of the committee chair to engage stakeholder participation at the committee level and to report back to the full Commission. Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings.~~

~~4.15~~ 4.14 Access to Commission Meeting Sites

Commission meeting sites are accessible to people with disabilities and should also be accessible by public transportation. Those who need special assistance may contact the meeting coordinator listed on the public agenda notice of the meeting.

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~~4.16~~ 4.15 Minutes and Motion Summaries

Minutes and motion summaries of each open session meeting are included in the meeting materials and posted on the Commission website at: www.MHSOAC.ca.gov. ~~distributed to Commissioners, the Executive Director, Chief Counsel, and selected staff for review~~. ~~After review and Commission approval, minutes and motion summaries are published on the MHSOAC Commission website at: www.MHSOAC.ca.gov.~~

PUBLIC OUTREACH AND ENGAGEMENT

5.1 The Commission seeks to ensure the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in the Commission's decisions and recommendations. The Commission ensures this through:

- Public hearings that have open, informed, and transparent deliberation.
- Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission.
- Community forums and listening sessions that are organized to highlight and understand topics specified by the Commission.
- Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges.

COMMITTEES/SUBCOMMITTEES/OTHER MULTI-MEMBER BODIES

6.1 ~~5.1~~ ~~Committee~~ Structure

A. The ~~MHSOAC~~ Commission ~~shall~~ may establish one or more ~~standing~~ committees as necessary to provide technical and professional expertise pursuant to Welfare and Institutions Code Section 5845 (d)~~(2)~~(3). Such committees provide guidance, review materials, and make recommendations to the ~~MHSOAC~~ Commission and, in rare instances, when given explicit and written delegated authority by the ~~MHSOAC~~ Commission, make decisions on behalf of the ~~MHSOAC~~ Commission.

A.1. The Commission Chair~~-elect~~ shall appoint a Chair and Vice Chair for each ~~standing~~ committee from among the Commission's membership who will assume their duties immediately upon appointment. ~~The Chair and Vice-chair for each standing Committee will assume his or her duties in January following the year he or she was appointed. Each year the Commission Chair may reappoint a Committee Chair and Vice-chair.~~

A.2. ~~Ideally~~ Each ~~standing~~ committee shall have a maximum of 15 members and may ~~shall~~ include public membership. Public membership of each committee shall be selected by the committee Chair and Vice Chair for a one-year term. Of this public membership, the committee Chair and Vice Chair shall seek individuals with the desired expertise who are consumers, family members or care givers of consumers, and members of underserved ethnic and cultural communities. ~~at least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair.~~ In their recruitment and appointment of committee members, committee Chair and Vice Chair shall pay special attention to issues related to cultural diversity and competency and the needed expertise to support the committee's goals. Commission staff and/or consultants will staff each committee.

A.3. The committee Chair may establish one or more multi-member body consisting of committee members in order to further the work of the committee.

A.4. If a committee member cannot attend a committee meeting the member shall notify the committee Chair and the committee staff member of such absence in advance of the committee meeting. If a committee member misses more than one committee meeting without notice or three committee meetings in a calendar year with notice, the committee Chair has discretion to decide whether it is in the best interest of the committee to have that committee member replaced.

~~The membership of each Committee will be confirmed every other year in odd numbered years at the January MHSOAC meeting. In the intervening time each Committee Chair has discretion to modify the Committee membership based upon the needs of the Committee.~~

~~The MHSOAC may establish an Operations Committee that is composed of the Chair or the Vice-chair of each standing Committee. The Commission Chair and Vice-chair are the Chair and Vice-chair of the Operations Committee. The Operations Committee is exempt from the public membership listed above and it is not authorized to take policy positions on behalf of the Commission unless the Commission specifically delegates such authority.~~ Convenience

B. The Commission may establish any multi-member body (e.g. committee, subcommittee, taskforce) consisting of Commissioners appointed by the Chair as necessary to support the work of the Commission.

6.2 ~~5.4~~ Bagley-Keene Open Meeting Act

A. Meetings of a committee, subcommittee, and multi-member body are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. ~~The principal law that governs the meetings of the MHSOAC and its Committees is the~~

~~Bagley-Keene Open Meeting Act which is set forth in Government Code Sections 11120 et seq.~~

B. A public agenda notice of a committee, subcommittee, or multi-member body meeting must be given and made available on the MHSOAC website at www.MHSOAC.ca.gov, at least 10 calendar days before the meeting. The public agenda notice will also be emailed to the Commission's list-serve. A copy of the public agenda notice will be sent to any person who requests it in writing ~~a PAN in writing must be sent a copy~~.

C. The public agenda notice of a committee, subcommittee, or multi-member body meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted.

D. The public agenda notice of a committee, subcommittee, or multi-member body meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act. (Government Code Section 11125)

E. ~~Upon request by a person with a disability the PAN~~ The public agenda notice of a committee, subcommittee, or multi-member body meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The ~~PAN~~ public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.

F. A committee, subcommittee, or other multi-member body may hold a meeting by audio or audio-visual teleconference (Government Code Sections 11123 and 11123.5). All public agenda notice requirements apply.

6.3 ~~5.3~~ Compensation and Expenses

~~Commissioners, staff,~~ Active members of committees, subcommittees or any other multi-member body and agendized presenters ~~and active Committee members will be~~ are eligible to be reimbursed in accordance with State per diem laws. ~~Also, any reasonable business expenses incurred will be reimbursed as authorized by the Commission. On a case-by-case basis a Committee member designee may also be reimbursed in accordance with the State per diem laws.~~

~~5.4 Public Agenda Notice (PAN)~~

~~A Notice of any Committee meeting must be given and made available on the MHSOAC website at www.MHSOAC.ca.gov, at least ten (10) calendar days before the meeting. The PAN will also be emailed to the MHSOAC list-serve. Any person who requests a PAN in writing must be sent a copy. The notice must include:~~

- Name, address, and telephone number of the individual who can provide additional information prior to the meeting
- Address of the internet site where notices are posted
- Specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed.

Upon request by a person with a disability the PAN shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The PAN shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.

WORKGROUPS

6.1 Establishment of Workgroups

The MHSOAC and its committees may establish workgroups, to focus on a specific dimension of the Commission or Committees' work. The workgroup is project focused with specific time limited deliverables.

The membership of the Workgroups will consist of a smaller body of Committee members who volunteer or are appointed by the Committee Chair and Vice-chair.

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AGENDA ITEM 7

Action

January 23, 2020 Commission Meeting
Adopt MHSOAC Strategic Plan

Summary: The Commission's Executive Director and staff from Applied Survey Research will present the Commission with a Final Draft Strategic Plan.

Background: The Commission began a strategic planning process in the fall of 2018 with the help of Applied Survey Research (ASR). With ASR's facilitation, the Commission held four public meetings, including several breakout sessions with the public, and two half-day meetings with Commission staff to receive their feedback and input into the process. Additionally, ASR conducted personal interviews, focused conversations, and received over 400 online survey responses from consumers, providers, families, and other stakeholders. The first draft of the Commission's Strategic Plan was presented to the Commission in September 2019 and the final plan that will be presented to the Commission in January 2020 includes the edits based on the discussion at that meeting.

Dr. Ewing also will present the Commission with a plan to implement the MHSOAC Strategic Plan.

Presenters: Toby Ewing, Executive Director, MHSOAC, Susan Brutschy, President, Applied Survey Research and Lisa Colvig-Niclai, Vice President of Evaluation, Applied Survey Research

Enclosure (2): (1) Draft Strategic Plan Summary (2) Draft Results-Based Strategic Plan 2019-2023; and (3) Implementation Plan (4) Past Implementation Plans

Handouts: A Power Point Presentation will be provided at the meeting.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

LYNNE ASHBECK
Chair
MARA MADRIGAL-WEISS
Vice Chair
TOBY EWING
Executive Director

January 21, 2020

MHSOAC DRAFT STRATEGIC PLAN 2020-2023

Summary

The Commission in 2019 conducted extensive outreach with public stakeholders and internally to identify the issues and opportunities that are incorporated into the draft strategic plan. The Commission received a presentation and discussed the major elements of the plan in September.

Based on the Commission's discussion, the staff crafted a narrative that provides context regarding the need for transformational change, the Commission's maturing role in driving that change in the public and private mental health systems, and how the Commission's functions are levers for change. The draft goals and objectives reflect the Commission's primary activities.

Highlights of the plan:

- **Clearly articulates the Commission's broad vision** for addressing mental health needs and improving mental wellbeing – and the imperative for transformational change to realize that vision.
- **Establishes three priority goals:** 1) advancing a common vision for reducing negative outcomes and improving mental wellness; 2) advancing data and analysis to drive policies and practices; and, 3) facilitating improvement and transformational change.
- **Describes the Commission's functions** as they have evolved and how those functions align to the levers for transformational change, including traditional functions such as oversight and accountability, as well as policy projects and strategic partnerships that allow the Commission to actively facilitate improvements and programs.
- **Provides a foundation for internal improvements** that will enable the Commission to more effectively fulfill new responsibilities authorized by legislation and seize opportunities identified by the Commission. Improvements are anticipated in internal procedures, organization and professional development.
- **Communicates the Commission's strategic perspective**, as well as specific goals and objectives to partners in state and local government, stakeholders and the new partners who will need to contribute to transformational change.

Next steps

The Executive Director will work with the Commission to use the plan to assess opportunities, ensure activities are aligned with goals and objectives, and evaluate the organization's performance.

The staff will work with the Commission's Evaluation Committee to complete the public outcome goals and to align internal metrics for assessing progress toward the plan's objectives.

The staff will work with the Commission's partners to assess and incorporate learnings from multi-county collaboratives.

The Executive Director will work with the staff to identify improvements in internal procedures and professional development to bolster the Commission's performance.

The staff will deploy the plan in communications to state and county partners, and in more public settings to establish a consistent narrative on the changes required to significantly improve results.

A VISION FOR TRANSFORMATIONAL CHANGE IN MENTAL HEALTH

Mental Health Services Oversight and Accountability Commission 2020-2023 Strategic Plan

The Mental Health Services Oversight and Accountability Commission developed this strategic plan in consultation with clients and families, community advocates, state and local policymakers, services providers and a variety of public and private sector partners.

As a result, the plan reflects the urgency of our times as the inadequacy of multiple public systems are compounded by changing social and economic conditions. Despite a seemingly prosperous economy, poverty and housing shortages, low wages and high costs, inadequate access to health care and other risk factors are contributing to unacceptably high levels of homelessness, childhood trauma, substance abuse and a variety of mental health needs.

At the same time, emerging scientific knowledge, new technologies and experience in system design makes it possible to prevent and respond more effectively to mental health needs.

The Commission's experience over the last 15 years – and its engagement with stakeholders over the last year in the strategic planning process – have reaffirmed the imperative for transformational change in public and private mental health systems to achieve the intended vision that everyone who needs care receives effective care when they need it.

California voters in enacting Proposition 63 in 2004 charged the Commission with catalyzing that change and advancing that inclusive vision. This strategic plan affirms the Commission's long-standing commitment to use its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

The Commission's Mission

The Commission works through partnerships to catalyze transformational changes across service systems so that everyone who needs mental health care has access to and receives effective and culturally competent care.

The Commission's Vision

Wellbeing for all Californians

The Commission's Core Principles

1. Wellness and recovery
2. Client-consumer and family-driven
3. Community collaboration
4. Cultural competency
5. Integrated service delivery

Terminology

The Commission uses the term mental health throughout this plan to include any services required to support a person's mental health and wellbeing, which could include services for substance use disorder, physical health, housing, or other needs.

The Promise of the Mental Health Services Act

The Mental Health Services Act was crafted to support transformational change in mental health care and the Mental Health Services Oversight and Accountability Commission was given the authority and responsibility to drive that change.

More than a funding stream, the Act seeks to counter the programmatic fragmentation, the rationing of care, and the narrow eligibility requirements that have frustrated efforts to develop effective and sustainable systems of care.

The Act requires counties to engage stakeholders – including those needing care and their families, other public agencies and care providers – to define services and desired outcomes.

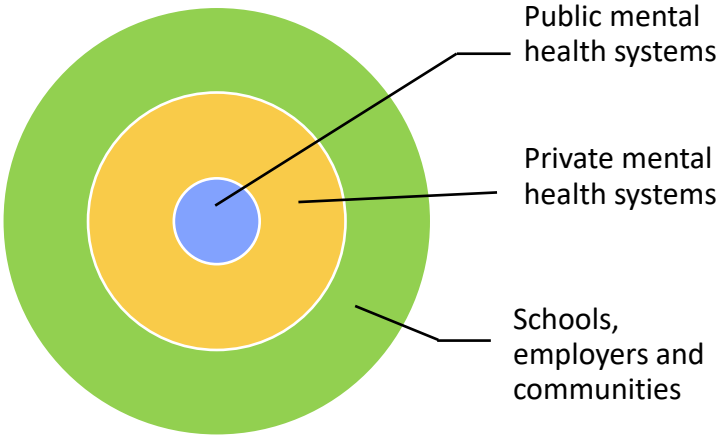
The Act dedicates funds to prevention and early intervention. The Act provides funds that can be used to link and leverage the resources from rigid entitlement programs. And the Act – acknowledging the need for new strategies and solutions to solve "persistent, seemingly intractable mental health challenges" – allocates resources for county-led innovation projects.

To fulfill the potential of the Act, the Commission considers how other financial resources and potential partners can be engaged to advance scientific knowledge, help reduce the risk of trauma, aid in early identification of mental health needs, provide supportive housing and employment, and expand the services covered by employer-sponsored health care.

This holistic perspective puts consumers and families at the center of decision-making. It elevates the integration of activities across systems – from public health, education and employment strategies, to child welfare and public safety – to achieve the shared goals of minimizing harm and maximizing wellbeing. A systems approach connects data to develop common understanding, smart policies and effective programs. Well-functioning systems coordinate funding, facilities and staffing, and they learn by evaluating and improving strategies and services.

Equally important, a holistic perspective illuminates the extraordinary opportunities to advance the mental wellness of all Californians through a public health approach; partnerships with schools, universities and employers; and, by uniting physical and behavioral health.

Potential Partners and Resources



The Imperative of Transformational Change

The Mental Health Services Act, in prioritizing prevention and early intervention to reduce severe and disabling mental illness, lists seven outcomes for improvement: suicide, incarceration, school failure, unemployment, prolonged suffering, homelessness and the removal of children from their home.

Californians continue to experience unacceptably high rates in each domain. The costs and consequences associated with incarceration and homelessness, in particular, are emerging as a priority for the public and public officials. The complexity of these heart-breaking cases requires public agencies to assertively move "upstream" to address the root causes of the problem.

More broadly, public agencies are under pressure to better respond to the social and economic trends that are eroding the social determinants of health, increasing a variety of health-related risks and eroding resiliency factors that enable people to manage and recover from adversity.

Transformational Change Defined

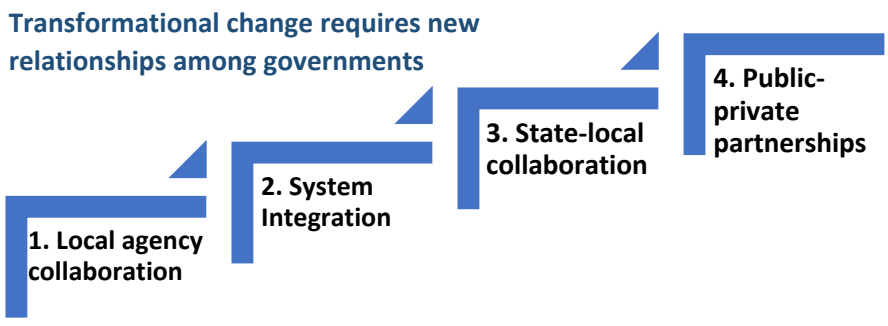
Transformational change fundamentally restructures organizational operations and cultures, policy frameworks, funding streams, programs and interventions to accelerate the pace and scale of improvements. Transformational change strategies produce exponential rather than incremental improvements. Transformed systems are adaptive, learning and sustainable.

Transformation in public systems requires deeper relationships among government agencies that are serving the same individuals, families and communities. Agencies must overcome organizational silos, a compliance-only mentality, and a scarcity view of resources.

Transformation also requires a new role for state government – aligning statues, regulations, funding and other policy infrastructure – to enable and encourage local collaboration.

State and local governments also need to partner with the private sector – including nonprofit organizations, philanthropies, employers, innovative companies, social impact investors – to link financial resources, technologies, and the capacity to innovate.

In addition to these new relationships, success will require extreme competence in the ability to execute, evaluate and continuously improve strategies, programs and services.



The Levers of Transformational Change

From a State perspective, and particularly from the view of the Mental Health Services Oversight and Accountability Commission, seven levers enable transformational system change:

1. **Goals and metrics** are required to establish agreement on desired outcomes, the commitment to do whatever it takes, and measure progress.
2. **Engaged diverse communities** – including consumers and families from different cultural and social backgrounds, service providers, local governments, employers and others involved in the public and privately funded behavioral health systems – drive changes needed to increase access to high quality services and improve outcomes.
3. **Data systems** inform policy-making, program design, service management and continuous improvement.
4. **Knowledge transfer** and access to information enables all public agencies, partnerships and communities to deploy the best possible solutions.
5. The **capacity to design, build and manage** programs and services enables agencies to integrate appropriate resources, develop service delivery systems and improve quality.
6. **Incentives,** including financial resources, enable and encourage agencies to take risks and take the initiative to start something new and try something different.
7. **Transparency and accountability** focus agency staff on goals, increase public trust and affirm a public commitment to improved outcomes.

These elements are essential for policymakers, executives, managers and professional staff to better communicate, cooperate, coordinate and collaborate to improve results.

<table>
<tr><th colspan="4">Levers for Transformational Change</th><th>System Impact</th></tr>
<tr><td colspan="2">Goal setting</td><td colspan="2">Data systems</td><td>Strategic direction & insight</td></tr>
<tr><td colspan="4">Engaged diverse communities</td><td>Authentic input & feedback</td></tr>
<tr><td>Knowledge transfer</td><td>Management capacity</td><td colspan="2">Incentives</td><td>Ability to execute</td></tr>
<tr><td colspan="4">Transparency & accountability</td><td>Political mandate & support</td></tr>
</table>

The Commission's Authorities, Capacities to Catalyze Transformation

The Mental Health Services Act constituted the Commission to promote a public health approach – with Commissioners who are consumers, family members and lawmakers; members from health and mental health care, education and law enforcement, employers and labor.

The Act also grants the Commission specific authorities and responsibilities. The Legislature has interpreted those authorities by directing the Commission to prepare strategies, coordinate actions among state and local governments, administer grants, and prepare voluntary standards to promote mental health far beyond the publicly funded mental health system. These authorities and responsibilities align well with the levers of transformational change.

1) **The oversight and accountability functions** provide transparency on funding, services and outcomes; articulate how fragmented and siloed programs can be coordinated and integrated; and, identify opportunities to link and leverage funding streams, including MHSA funds, to improve results.

2) **Program review and data collection** baseline current practice and impact; assess gaps in the service continuum; assist in developing, monitoring and communicating improvement efforts within and among counties; and, identify opportunities to change practices to support system-scale improvements.

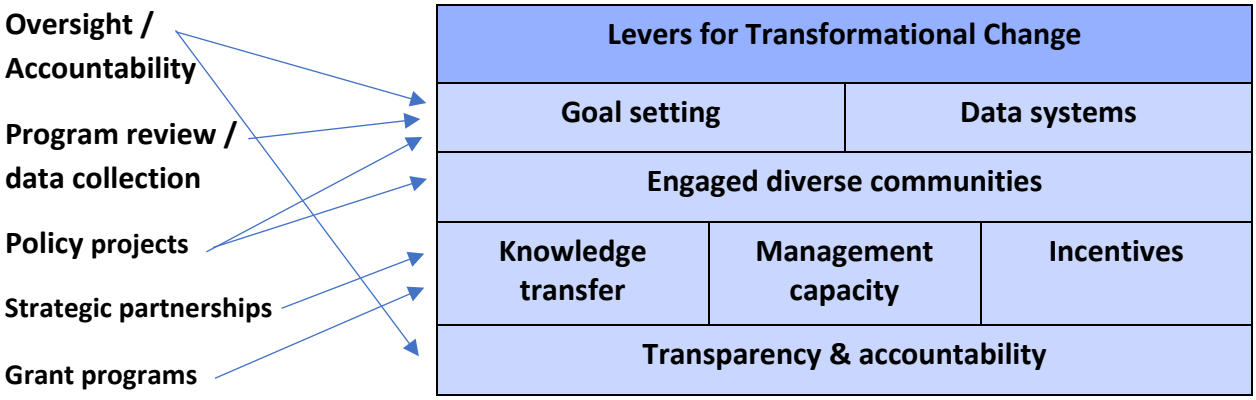
3) **Policy projects.** The Commission, upon direction from the Legislature and under its own initiative, executes projects designed to elevate and integrate research findings, experiential knowledge, and the wisdom of those with lived experience in order to articulate changes needed in systems and policies. The Commission's projects include criminal justice involvement, the state suicide prevention plan, workplace mental health standards, prevention and early intervention strategies, and school-based mental health.

4) **Strategic partnerships.** The Commission partners with universities, institutes, civic entrepreneurs and other public agencies to develop, field-test and implement system changes and policy solutions. The Commission's partnerships include the Full Service Partnership Pilot, the Early Psychosis Learning Health Care Network, the Youth Innovation Project, and the multi-county collaboratives of an Innovation Incubator – all of which are connecting researchers, county leaders and practitioners to learn from each other, deploying the latest knowledge and building the capacity for continuous improvement.

5) **Grant programs.** The Commission manages grant programs that resource essential and innovative services in ways that incentivize stronger partnerships, integrated services, braided funding and the evaluation required for continuous improvement. The Mental Health Wellness Act (Triage), youth drop-in centers, the early psychosis project, and the Mental Health Student Services Act are examples of such grants.

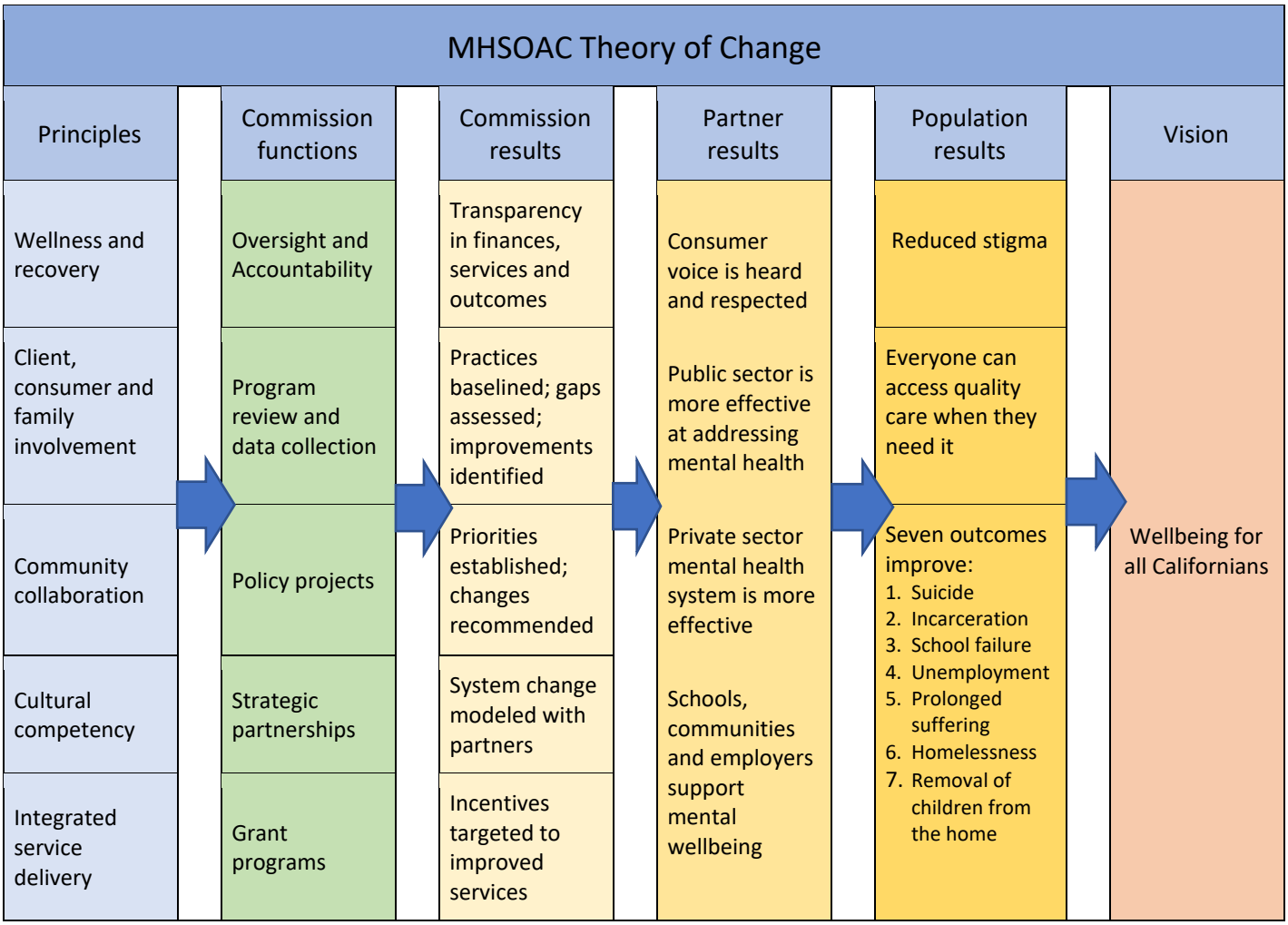
The Commission's five primary functions align with the levers for transformational change and can be used to strategically drive change to systems, policies and practices.

Commission Capacities



Theory of Change

The theory of change shows how principles inform actions to produce results to advance the vision.



Priorities and Objectives for 2020-2023

The Commission's vision – "wellbeing for all Californians" – requires a broad public understanding of the potential to prevent, treat and recover from mental health issues; and those in need of care must have access to high quality, affordable and increasingly effective care. To advance this vision, the Commission commits to the following goals and objectives:

Advance a Shared Vision

Strategic goal 1: The Commission will advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.

Objectives:

1a. Promote school mental health as a prime opportunity to reach and serve at-risk children, families and neighborhoods.

- Implement the Mental Health Student Services Act, including working with grantees to capture learnings, improve efforts and achieve system-scale sustainability.
- Advance the principles and recommendations in the Commission's school mental health report by guiding legislation, future state investments and community partnerships.

1b. Develop and advance a strategy for aligning public and private resources and actions toward the prevention and early intervention of mental health needs.

- As directed in SB 1004, distill and disseminate knowledge on how mental health issues can be prevented, detected early and addressed at population scale.
- Integrate a robust monitoring strategy for prevention and early intervention spending into the Commission's review of county reporting documents and the Commission's Transparency Suite.
- Improve technical assistance and related activities to more effectively build capacity at the community level to coordinate resources and services to improve outcomes.
- Communicate the potential to prevent mental health issues to public and private sector decisionmakers.

1c. Establish and promote the adoption of voluntary standards for the workplace to reduce stigma, increase awareness, and guide strategies to support mental health and wellness.

- As directed by SB 1113, and in consultation with employers, employees and other stakeholders, develop voluntary standards for adoption by private and public sector employers.

- Develop and propose an implementation strategy, including ways to promote, support and evaluate programs to document costs, benefits and opportunities for improvement.

Advance Data, Analytics and Opportunities to Improve Results

Strategic goal 2: The Commission will advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.

Objectives:

2a. Further develop the Transparency Suite at MHSOAC.CA.GOV to capture more detailed information that is easier to find and interpret.

- Work with state and county agencies to capture accurate and consistent fiscal, program and outcome data from revenue and expenditure reports, three-year plans, annual updates, annual and three-year PEI evaluation reports, and innovation plans and final reports
- Deploy the technology so information can be efficiently integrated into the system and easily found by stakeholders who want the information to design, manage or evaluate policies and programs.

2b. Refine the Commission's management of county-level information to better inform decision-making by state and county policymakers and administrators.

- Better manage county-level data – including the county reports listed above, as well as Full Service Partnership and client service information – to accelerate the transfer of knowledge and strengthen the capacity of counties to design, build and manage more accessible and cost-effective services.

2c. Further develop the Commission's capacity to aggregate and integrate cross-system data, including data regarding health and mental health, education, employment and criminal justice to assess system performance and identify opportunities for improvement.

- Acquire and curate data from all relevant state agencies, including the departments of Education, Employment Development, Justice, Social Services and State Hospitals, and the Office of Statewide Health Planning and Development.
- Collaborate with other state-level efforts to integrate and deploy data to improve state policies, resource allocation, and access to services and outcomes, including the Governor's proposed Center for Data Insights and Innovation.

Catalyze Improvement in Policy and Practice

Strategic goal 3: The Commission will catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

Objectives:

3a. Support and evaluate multi-county collaboratives striving to improve data analysis, the transfer of knowledge, and the management capacity required to improve results.

- Support the Full Service Partnership pilot to identify ways to improve this significant investment in addressing serious mental illness.
- Support the Early Psychosis pilot to advance the transfer of knowledge and capacity building for more effective detection and response to early experiences with mental health issues.
- Complete and oversee the projects of the Innovation Incubator and document the value of efforts to form and support collaborations to address specific issues.

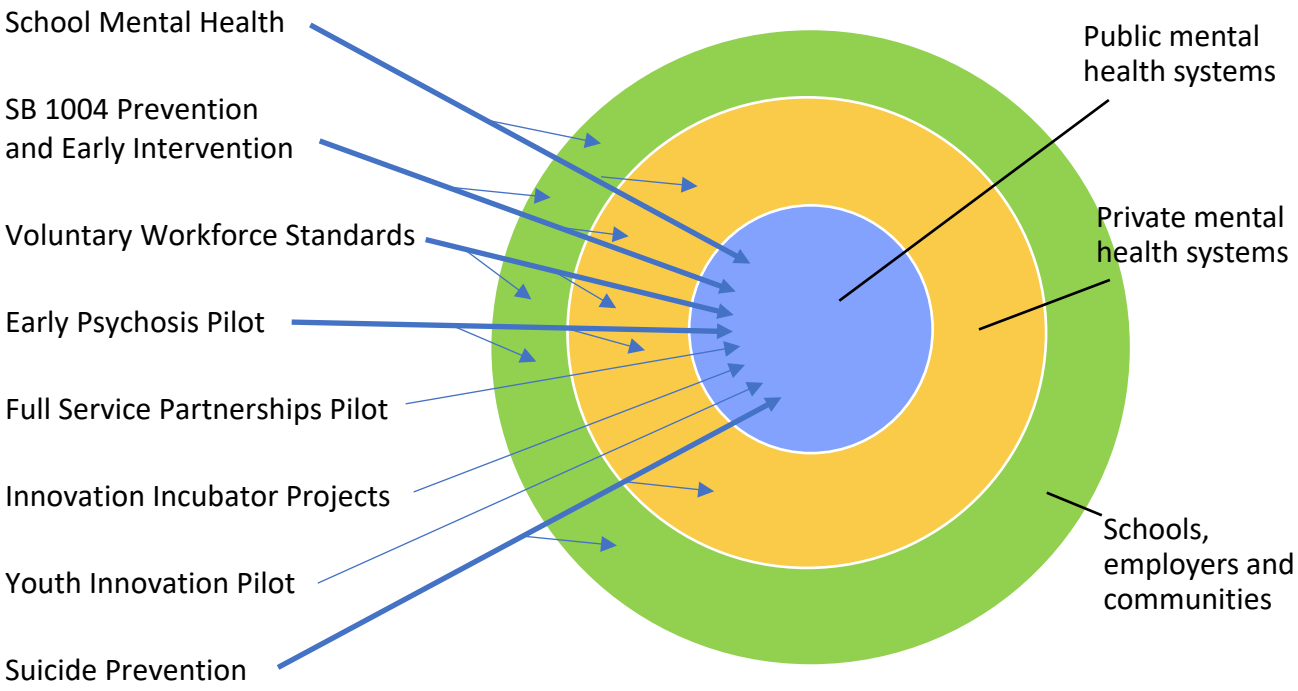
3b. Support implementation of Striving for Zero, the State's suicide prevention plan for 2020-25.

- Work with the Governor, the Legislature and community leaders to establish an Office of Suicide Prevention, expand training resources, better integrate suicide prevention services into health care setting, and encourage the renewal of community prevention plans.

3c. Support youth-led efforts to advance and expand practices for consumer-led and consumer-centric services and expand access to youth-focused services.

- Support the Youth Innovation Committee in developing practices that engage youth in the design, delivery and evaluation of services; encourage counties to adopt those practices.
- Distribute funds to expand Youth Drop-In centers to improve access to care for young people.

Commission's Policy Projects and Partnerships Target Transformational Change



From Plan to Action

The strategic plan provides a coherent framework to inform and align the Commission's deliberations and decisions. The plan articulates specific objectives to focus the Commission's daily operations. And the plan communicates the Commission's priorities to partners, stakeholders and the public.

The Commission will assertively implement the plan, measure and assess progress, and refine and update the plan in response to legislation, events and experience. Five near-term opportunities:

1. **Effective use of Commission resources.** The Commission will rely on the plan to allocate financial resources and how the Commission spends its time and related staff resources, particularly on policy projects, oversight and accountability activities. In 2020, for example the Commission will develop a state strategy for prevention and early intervention and voluntary standards for workforce mental health – two prime opportunities to advance the vision of wellbeing for all Californians.

2. **Data, measurement and evaluation.** The Commission's Evaluation Committee will play an essential role in refining measures for the seven negative outcomes and in developing an evaluation strategy to inform state policy and community practice. The Commission staff

also will develop specific measurable, achievable, realistic and time-bound metrics for each of the objectives in the plan, and publicly report progress using those metrics.

3. **Strategic partnerships.** Many of the strategic partnerships initiated by the Commission in the last four years are beginning to show results in terms of their intended objectives, as well as the potential for collaboration among counties and with the state to initiate transformational change. The Commission in 2020 will work with partners to look across those projects for lessons and insights.

4. **Internal improvements.** The Commission staff in 2020 will review internal procedures and operations to identify ways to more efficiently and effectively perform each of the Commission's functions.

5. **Communications.** The Commission in 2020 will significantly improve the quality and quantity of communications to improve public understanding of mental health needs, the potential for recovery, the value of services and the opportunity for transformational change to significantly improve results.

Commission Results Framework

Mental Health Services
Oversight & Accountability Commission

Results

FUNCTION	RESULT	PROCESS AND RESULT MEASURES	METHOD
Engage diverse communities	Commission and partners embrace multiple perspectives on mental health needs and disparities to make informed decisions	# of community forums/ events held or attended, by target population and location	Outreach Log
		Diversity of the Commission: % of Commissioners who reflect targeted populations (consumers, other underrepresented population)	Commission roster
		% of targeted entities (commissioners, staff, counties, partners) who feel that MHSOAC is making decisions based on the needs of diverse communities	Annual Survey
Shape policy	Commission identifies priorities, and standards and supports effective policies and practices	Number of MHSOAC policy projects, programs or strategies being implemented ("active project list")	Log
		% of targeted entities (commissioners, staff, counties, partners) who feel they know what MHSOAC's agenda/ priorities are	Annual Survey
		# of policies, procedures, or standards identified as needing clarification	Log
		# of trainings given to improve adherence to policies, procedures or standards	Log
		# of targeted policies, procedures or standards that have improved adherence	Log
Conduct oversight	Commission promotes transparency and accountability for finances, services, and outcomes	# of web hits on the Transparency Suite	Analytics
		# of corrective actions taken based on Transparency Suite data	Log
		# site visits to monitor oversight / measure shared learning	Log
		% of annual fiscal reports received	Log
		% of funds expended	Log
		# of "county amends" to county programs (including budget changes)	Log
		% of compliance reports received (regulatory and non-regulatory)	Log
		# of compliance reports sent (regulatory and non-regulatory)	Log
		% of quarterly compliance reports needing corrective action	Log
		% counties complying with PEI evaluation requirements	Log
		% of counties effectively utilizing MHSA funds	Transp. Suite
		% of targeted entities (commissioners, staff, counties, partners) who feel that MHSOAC is effectively assuring oversight, transparency and accountability	Annual Survey
Drive systems improvement	Commission supports system improvement through policy, research, technical assistance, facilitation, and incentives	# of policies/legislation developed	Log
		# of policies adopted by Commission	Log
		# of policies adopted by legislation	Log
		# of policies implemented, by budget allocated	Log
		#/ % counties receiving TA during implementation	Technical Assistance "Ticket" tracker
		#/% of counties using INN toolkit	Log
		% of programs (counties?) utilizing funds to target youth/TAY	Log

FUNCTION	RESULT	PROCESS AND RESULT MEASURES	METHOD
		# meetings with SMEs (clarify)	Log
		% of counties who feel supported by MHSOAC to effectively implement their work	Annual Survey
		# of positive outcomes reported from counties	Desk review
		# of new county programs created, by targeted population	
		% of targeted entities (commissioners, staff, counties, partners) who feel that MHSOAC is effectively facilitating and incentivizing systems improvement and client outcomes	Annual Survey
Monitor and evaluate	Metrics are established to support outcomes for system improvements	Metrics for MHSOAC from the Results Framework are finalized	Results Scorecard
		Results scorecard is updated quarterly	Results Scorecard
		# of staff reviews of Scorecard data per quarter	Log
		# of actions taken as a results of Results Scorecard	Log
	Effective practices are identified (and shared)	# of projects deemed effective and worthy of replication	Log
		# of communications to partners that identify and share lessons learned	Log
Communicate!	Policy makers and the public are aware of mental health needs, opportunities, and systems change efforts and results	# of communication efforts / products	Log
		% of targeted entities (commissioners, staff, counties, partners) who recall receiving information from MHSOAC about mental health needs, opportunities, and systems change efforts and results	Annual Survey

Partner Results *(measures pending)*

	RESULT	MEASURE	METHOD
The public sector effectively addresses mental health	Counties continuously improve access, quality, and client outcomes	# of calls to county access lines	
		Increased penetration rate for publicly-funded MH benefits	
		# of programs with demonstrated positive client outcomes	Transparency Suite
		# of counties who have created learning communities (Triage and non-Triage counties)	Log
		% of counties whose learning communities are actively driving change	Survey
		$ allocated in LCs, per county	Log
		% of collaborative that identified goals reached	Survey
	Integrated approaches are used to address MH across sectors (i.e., education, criminal justice, housing, child welfare)		
	Effective strategies are scaled up across the state	# of programs that are replicated across multiple counties	Transparency Suite
	Policy, funding, and regulatory barriers are addressed		
The private sector supports mental health	Commercial or private sector insurers provide consumers with appropriate access to effective mental health care		
	Employer standards & policies support mental health		
The population supports mental health	The public supports mental health as an essential part of overall health and wellbeing		

Population Results *(measures pending)*

	RESULT	MEASURE	METHOD
California's population is better off	Reduced stigma related to mental health	Increased penetration rate for publicly funded MH benefits	DHCS
		Increased penetration rate for privately funded MH benefits	
	Everybody who needs care gets care when and where they need it	Increased penetration rate for publicly funded MH benefits	DHCS
		Increased penetration rate for privately funded MH benefits	
	Reduced prevalence and disparity in 7 negative outcomes:	Children removed from their home • Overall • By disproportionally affected populations	UC BERKELEY, California Child Welfare Indicators Project
		School failure • Overall • By disproportionally affected populations	CDE, DATAQUEST
		Unemployment • Overall • By disproportionally affected populations	EDD
		Criminal justice involvement • Overall • By disproportionally affected populations	CA ATTORNEY GENERALS OFFICE
		Homelessness • Overall • By disproportionally affected populations	TBD
		Prolonged suffering • Overall • By disproportionally affected populations	TBD
		Suicide • Overall • By disproportionally affected populations	CDPH – COUNTY HEALTH STATUS PROFILES
Wellbeing for All Californians	Increased wellbeing for all	% of California residents with strong life satisfaction	Cantril Ladder of life satisfaction

Mental Health Services
Oversight & Accountability Commission

Results-based Strategic Plan 2019-2023

Implementation Plan

December 2019

Prepared in partnership with Applied Survey Research

Next Steps for Implementation

The Theory of Change sets the strategic direction for the Commission.

How will this direction be shared with partners? How will the Commission track and communicate the difference it is making?

An Implementation Plan is being prepared which provides concrete next steps for:

1. Implementing and Sustaining the Strategic Plan
2. Measuring Results: Results Framework and Scorecard
3. Communicating Progress

Implementing and Sustaining the Strategic Plan

A plan is just a plan until it is put into motion. Below are suggested steps to launch and sustain implementation of the Commission's Strategic Plan:

1	**Align efforts and results**	The Commission should review and align current projects to desired results. Some activities will directly align with a result, while other activities may not align and may be scaled back.
2	**Keep nimble**	The Commission should adjust the Strategic Plan regularly in order to coincide with new partner projects, initiatives, measurement opportunities, and lessons learned.
3	**Conduct updates**	The plan should be refreshed every three years and include an inclusive input process led by commissioners and staff.
4	**Tackle the details**	An operational plan should be developed to address tactical and procedural needs, such as rules of procedure, committee structure, how learnings are shared, communication of progress about the Strategic Plan, and process for modifying the Results Scorecard.

Measuring Results: Framework and Scorecard

"What gets measured gets done," so the adage says. The steps below will help finalize the Commission's Results Framework and Scorecard to track and communicate progress.

1	**Finalize measures**	Review the draft measures and indicators; prioritize the ones that are 1) the most meaningful and 2) can be tracked. Create a glossary of agreed upon terms such as "result", "indicator," "measure."
2	**Collect data**	For each measure or indicator, agree who will take the lead on data collection, as well as when data should be collected. Agree on who will populate the Scorecard.
3	**Use the Scorecard**	Create and implement a process for data utilization: team reviews, sharing with partners, making key data points public (e.g. on the Transparency Suite).
4	**Refine when needed**	Meet every year to review the Scorecard and decide: Is it helping tell story of the difference made by MHSOAC or partners? Make adjustments where needed.

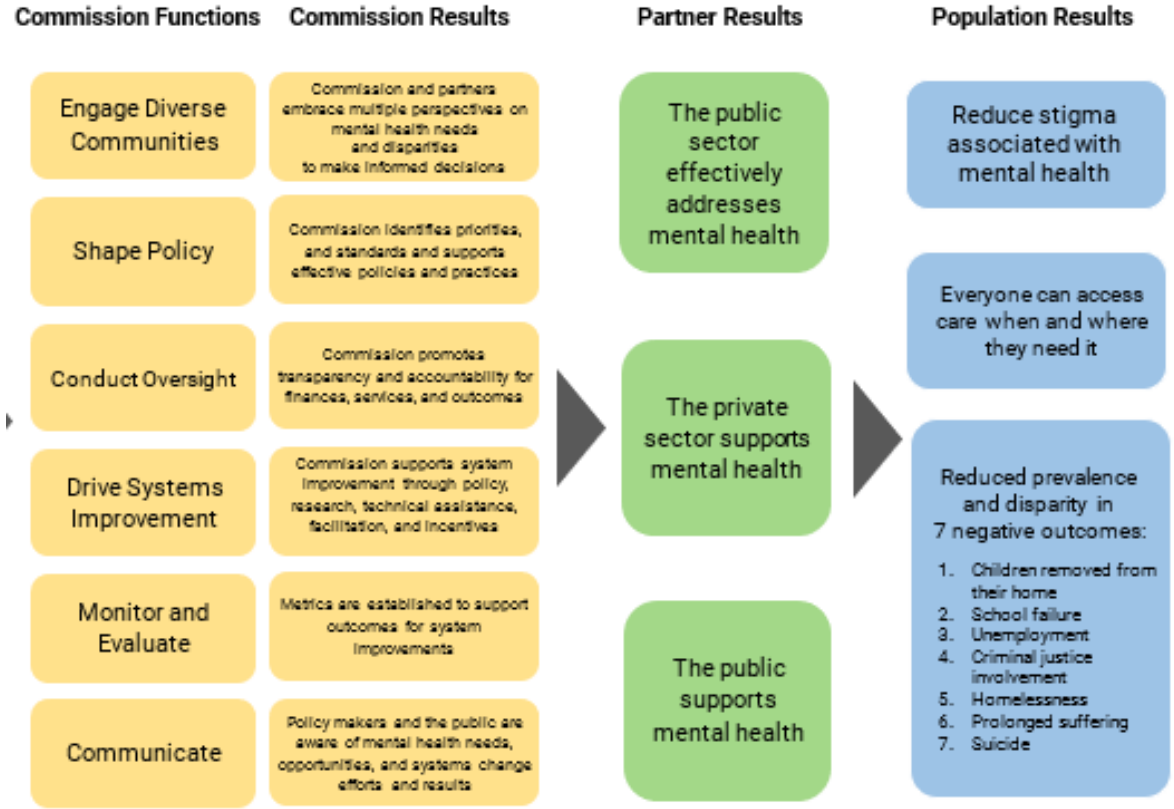
Results Framework:

The Results Framework is a rubric to measure:

- Commission results
- Partner results
- Population-wide results

The following presents examples of measures and indicators per result area.

These will be refined in 2019-20.



Excerpt from the Results Framework *

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		# of targeted policies, procedures or standards that have improved adherence	Log
Conduct oversight	Commission promotes transparency and accountability for finances, services, and outcomes	# of web hits on the Transparency Suite	Analytics
		# of corrective actions taken based on Transparency Suite data	Log
		# site visits to monitor oversight / measure shared learning	Log
		% of annual fiscal reports received	Log
		% of funds expended	Log
		# of "county amends" to county programs (including budget changes)	Log
		% of compliance reports received (regulatory and non-regulatory)	Log
		# of compliance reports sent (regulatory and non-regulatory)	Log
		% of quarterly compliance reports needing corrective action	Log
		% counties complying with PEI evaluation requirements	Log

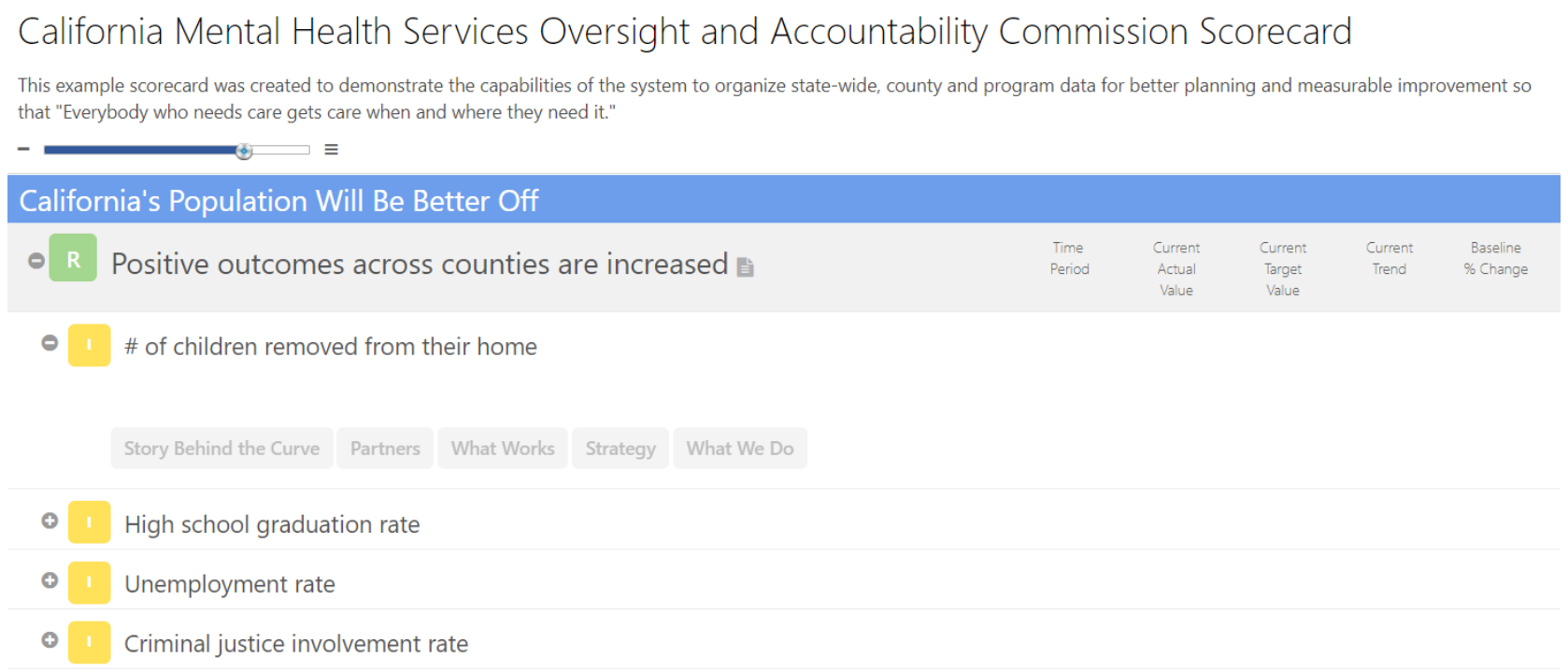
* Measures are still undergoing refinement.

Results Scorecard

The Results Scorecard is a live, web-based platform that will be used to communicate the status on the measures that matter most.

Click here!

https://app.resultsscorecard.com/Scorecard/Embed/48732



Communicating Progress

One of the recurring themes uncovered during the strategic planning process is that partners would like to better understand the Commission's efforts. Below is an implementation plan for communication to better tell the story of the Commission's results.

1	**Share the Plan**	Develop a two page overview of the Plan. Share the Plan broadly on the Commission's website and social media. Train a cadre of staff and Commissioners to share the full Plan (in PPT) Conduct webinars with county and community-based partners about the Plan.
2	**Share progress**	Create engaging formats to share Strategic Plan progress (Scorecard, social media, two page topical snapshots).
3	**Seek feedback**	Loop back to partners in 2020 to assess how well they feel informed about the Commission's core work and progress, and which products or formats they would like to see more of.

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Results-Based Strategic Plan 2019-2023

Transforming California's Mental Health Services to Achieve Wellbeing for All

Table of Contents

Strategic Planning Goals

In 2018, the Mental Health Services Oversight and Accountability Commission embarked on a strategic planning journey to:

- Clarify the core purpose, scope and role of the Commission with a focus on transforming mental health services in California.
  - Short term results that the Commission can achieve
  - Aspirational results for California
- Help the Commission move from “lower value” to “higher value” strategies
- Create a framework for measuring results and understanding the impact of the Commission’s work

The Commission's Vision, Mission and Principles

Mission

The Commission's mission is to work in partnership to catalyze transformational changes across systems and ensure everyone can access care when they need it.

Core Principles

- Wellness and recovery
- Client, consumer, and family driven
- Community collaboration
- Cultural competency
- Integrated service delivery

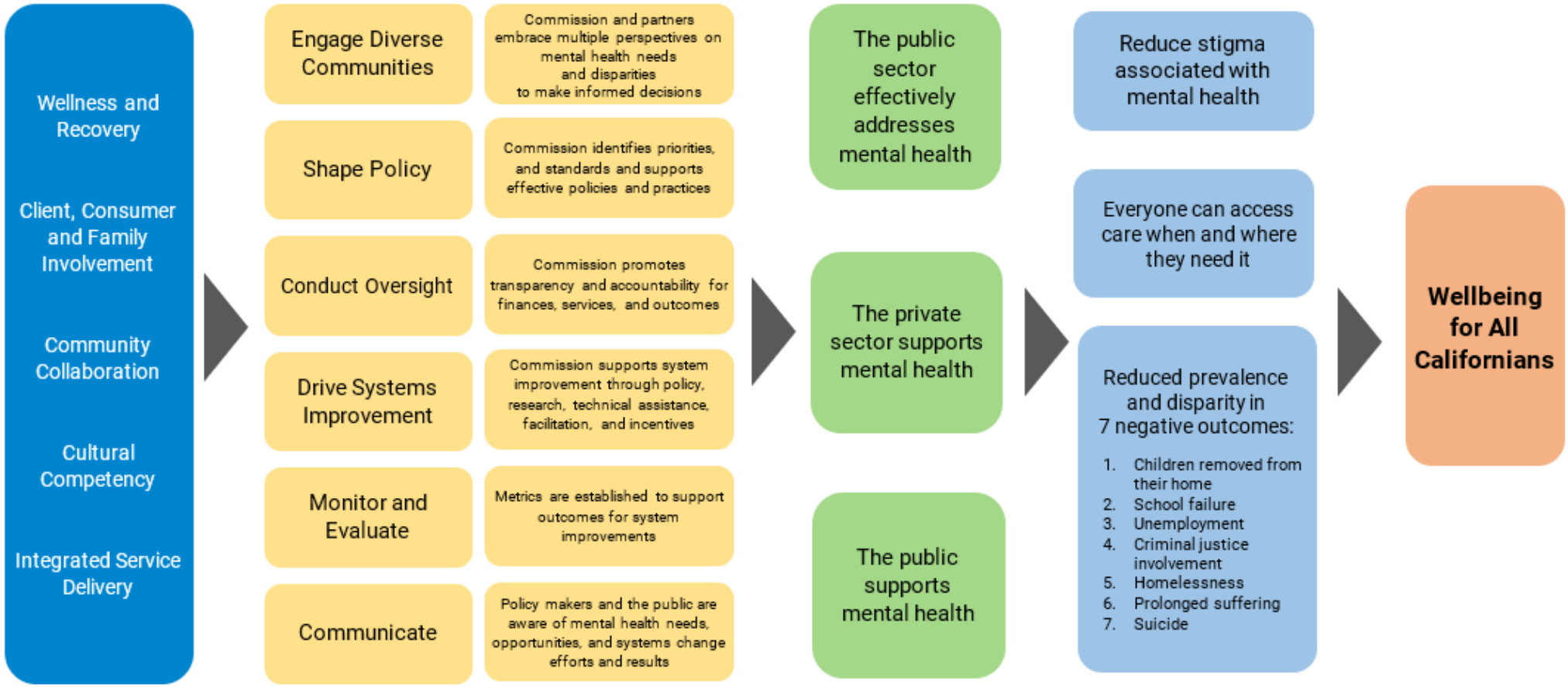
Vision

Wellbeing for all Californians.

The Commission' purpose is to transform the delivery of mental health services in California.

The Commission's Theory of Change

Our mission is to work in partnership to catalyze transformational changes across systems and ensure everyone can access care when they need it. Here's how:



The Commission's Core Functions and Results

To accomplish our mission, the Commission pursues several results.

In addition, the Act also grants the Commission broad authority to:

"Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted"

(WIC 5845 (d))

Engage Diverse Communities (WIC 5846(d))	Commission and partners embrace multiple perspectives on mental health needs and disparities to make informed decisions
Shape Policy (WIC 5845(d))	Commission identifies priorities, and standards and supports effective policies and practices
Conduct Oversight (WIC 5845(a))	Commission promotes transparency and accountability for finances, services, and outcomes
Drive Systems Improvement (WIC 5846)	Commission supports system improvement through policy, research, technical assistance, facilitation, and incentives
Monitor and Evaluate (WIC 5845 (d))	Metrics are established to support outcomes for system improvements
Communicate (WIC 5845 (d))	Policy makers and the public are aware of mental health needs, opportunities, and systems change efforts and results

Partner Results: Public Sector, Private Sector, the Public

To contribute to a vision of wellbeing for all Californians, the Commission is a catalyst for change in:

1. The public mental health system
2. The private sector
3. The public at large

To support transformation in these areas, the Commission:

- Set shared goals, standards, and metrics across the mental health system
- Gather and share data about what is working, what is not, and how to improve outcomes

The public sector effectively addresses mental health

The Public Sector:

- Counties continuously improve access, quality, and outcomes
- Integrated approaches are used to address MH across sectors (i.e., education, criminal justice, housing, child welfare)
- Effective strategies are scaled up across the state
- Policy, funding, and regulatory barriers are addressed

The private sector supports mental health

The Private Sector:

- Commercial or private sector insurers provide consumers with appropriate access to effective mental health care
- Employer standards & policies support mental health

The public supports mental health

The Public:

- The public supports mental health as an essential part of overall health and wellbeing

Population Results: A Shared Vision of Wellbeing for All

If the Commission is effective in its core work, and key changes occur within the public mental health system, the private sector, and the public at large, the desired results for the whole population include:

- Reduced stigma related to mental health
- Everyone can access quality, affordable care when and where they need it
- Reduced prevalence and disparity in the 7 negative outcomes listed in the Mental Health Services Act.
- Wellbeing for all Californians

Reduced stigma related to mental health care

Everyone can access care when and where they need it

Reduced prevalence and disparity in these 7 negative outcomes:

1. Children removed from their home
2. School failure
3. Unemployment
4. Criminal justice involvement
5. Homelessness
6. Prolonged suffering
7. Suicide

Wellbeing for All Californians

Next Steps for Implementation

The Theory of Change sets the strategic direction for the Commission.

How will this direction be shared with partners? How will the Commission track and communicate the difference it is making?

An Implementation Plan is being prepared which provides concrete next steps for:

1. Implementing and Sustaining the Strategic Plan
2. Measuring Results: Results Framework and Scorecard
3. Communicating Progress

AGENDA ITEM 8

Action

January 23, 2020 Commission Meeting
Legislative Priorities for 2020

Summary: The Commission will consider legislative priorities for the current legislative session, including consideration of the following:

Assembly Bill XX (Quirk-Silva): Assemblymember Quirk-Silva will present a legislative proposal that she plans to put forward this year. The legislative proposal would strengthen mental health strategies to respond to persons with co-occurring mental health needs.

Senate Bill 803 (Beall): Peer Support Specialist Certification Act of 2020
This bill establishes a statewide certification program for peer support specialists and provides the structure needed to maximize the federal match for peer services under Medi-Cal. The program defines the range of responsibilities and practice guidelines for peer support specialists, specifies required training and continuing education requirements, determines clinical supervision requirements, and establishes a code of ethics and processes for revocation of certification.

Senate Bill 854 (Beall): Mental Health Parity: Access to SUD Treatment
This bill prohibits a mental health plan or insurer from imposing any prior authorization requirements or any step therapy requirements before authorizing coverage for FDA-approved prescriptions. It also places the FDA-approved medications for treatment of substance use disorders on the lowest cost-sharing tier.

Senate Bill 855 (Wiener): Mental Health as a Medical Necessity
This bill strengthens the California Parity Act to require that insurers cover medically necessary treatment for all mental health and substance use disorders (MH/SUD), in addition to emergency care.

Presenters: Assemblymember Quirk-Silva; Toby Ewing, Executive Director, MHSOAC

Enclosures (4):

1. Senate Bill 803 (Beall) - Introduced January 8, 2020
2. Fact Sheet - Senate Bill 803 (Beall) – Peer Support Specialist Certification Act of 2020
3. Fact Sheet - Senate Bill 854 (Beall) - Mental Health Parity: Access to SUD Treatment
4. Fact Sheet – Senate Bill 855 (Wiener) – Mental Health as a Medical Necessity

Handout: None

SENATE BILL No. 803

Introduced by Senator Beall
(Principal coauthor: Assembly Member Waldron)
(Coauthors: Senators Wiener and Wilk)
(Coauthors: Assembly Members Aguiar-Curry, Arambula, Grayson, Reyes, and Weber)

January 8, 2020

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 803, as introduced, Beall. Mental health services: peer support specialist certification.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services.

This bill would state the intent of the Legislature to create a peer support specialist certification program administered by the Department of Consumer Affairs.

This bill would also require the State Department of Health Care Services to amend the Medicaid state plan to include a certified peer support specialist as a provider type for purposes of the Medi-Cal program and to include peer support specialist services as a distinct service type for purposes of the Medi-Cal program. The bill would require Medi-Cal reimbursement for peer support specialist services to

be implemented only if, and to the extent that, federal financial participation is available and the department obtains all necessary federal approvals. The bill also would authorize the department to implement, interpret, or make specific its provisions by means of informal notices, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2021, and, commencing July 1, 2021, would require the department to provide semiannual status reports to the Legislature until regulations have been adopted.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Peer Support Specialist Certification Program Act of 2020.

SEC. 2. Article 1.4 (commencing with Section 14045.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.4. Peer Support Specialist Certification Program

14045.10. The Legislature finds and declares all of the following:

(a) With the enactment of the Mental Health Services Act in 2004, support has been on the rise to include peer providers, identified as consumers, parents, and family members, for the provision of services.

(b) Peer providers in California provide individualized support, coaching, facilitation, and education to clients with mental health care needs and substance use disorders in a variety of settings, yet no statewide scope of practice, standardized curriculum, training standards, supervision standards, or certification protocol is available.

(c) The United States Department of Veterans Affairs and at least 48 states utilize standardized curricula and certification protocols for peer support services.

(d) The federal Centers for Medicare and Medicaid Services (CMS) recognizes that the experiences of peer support specialists,

as part of an evidence-based model of care, can be an important component in a state's delivery of effective mental health and substance use disorder treatment. The CMS encourages states to offer comprehensive programs.

(e) A substantial number of research studies demonstrate that peer supports improve client functioning, increase client satisfaction, reduce family burden, alleviate depression and other symptoms, reduce homelessness, reduce hospitalizations and hospital days, increase client activation, and enhance client self-advocacy.

(f) Certification can increase the diversity and effectiveness of the behavioral health workforce through the use of peers with lived experience.

14045.12. It is the intent of the Legislature that the peer support specialist certification program, established by the Department of Consumer Affairs under this article, achieve all of the following:

(a) Support the ongoing provision of services for beneficiaries experiencing mental health care needs, substance use disorder needs, or both, by certified peer support specialists.

(b) Support coaching, linkage, and skill building of beneficiaries with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Increase family support by building on the strengths of families and helping them achieve a better understanding of mental illness in order to help beneficiaries achieve desired outcomes.

(d) Provide part of a continuum of services, in conjunction with other community mental health services and other substance use disorder treatment.

(e) Collaborate with others providing care or support to the beneficiary or family.

(f) Assist parents, families, and beneficiaries in developing coping mechanisms and problem-solving skills in order to help beneficiaries achieve desired outcomes.

(g) Promote skill building for beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

(h) Encourage employment under the peer support specialist certification to reflect the culture, ethnicity, sexual orientation,

gender identity, mental health service experiences, and substance use disorder experiences of the people whom they serve.

14045.13. For purposes of this article, the following definitions shall apply:

(a) "Certification" means the activities of the certifying body related to the verification that an individual has met all of the requirements under this article and that the individual may provide mental health services and substance use disorder treatment pursuant to this article.

(b) "Certified" means all federal and state requirements have been satisfied by an individual who is seeking designation under this article, including completion of curriculum and training requirements, testing, and agreement to uphold and abide by the code of ethics.

(c) "Code of ethics" means the standards to which a peer support specialist is required to adhere.

(d) "Peer support specialist" means a person who is 18 years of age or older and who is a person who has self-identified as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer.

(e) "Peer support specialist services" means culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and maintenance of skills learned in other support services. Peer support specialist services shall include, but are not limited to, support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified peer support specialist.

(f) "Recovery" means a process of change through which an individual improves their health and wellness, lives a self-directed life, and strives to reach their full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based on the individual and their cultural community.

14045.19. (a) The State Department of Health Care Services shall amend its Medicaid state plan to do both of the following:

(1) Include a peer support specialist certified pursuant to this article as a provider type for purposes of this chapter.

(2) Include peer support specialist services as a distinct service type for purposes of this chapter, which may be provided to eligible Medi-Cal beneficiaries who are enrolled in either a Medi-Cal managed care plan or a mental health plan.

(b) The State Department of Health Care Services may seek any federal waivers or other state plan amendments as necessary to implement the certification program provided for under this article.

14045.21. Medi-Cal reimbursement for peer support specialist services shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

14045.23. For the purpose of implementing this article, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance.

14045.24. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific Section 14045.19 by means of informal notices, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. The State Department of Health Care Services shall adopt regulations by July 1, 2021, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2021, the State Department of Health Care Services shall provide semiannual status reports to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

O

SENATOR JIM BEALL

SB 803 Peer Support Specialist Certification Act of 2020

Principal Co-author Assemblymember Marie Waldron
Co-authors Senator Wiener and Senator Wilk
Assemblymembers Aguiar-Curry, Arambula Aguiar-Curry, Grayson, Ramos and Wicks

BACKGROUND

A peer is a person who draws on lived experience with mental illness and/or substance use disorder and recovery, bolstered by specialized training, to deliver valuable support services in a mental health and/or substance use setting. The U.S. Department of Veterans Affairs and 48 states have a certification process in place or in development for mental health peer support specialists. Demand for peer services is growing, but there is no statewide scope of practice, training standards, supervision standards, or certification in California.

STATEWIDE CERTIFICATION

Statewide certification would ensure quality, standardization, and effectiveness of peer support services across California's 58 counties.

The federal Centers for Medicare and Medicaid released guidance in 2007 for establishing a certification program for peers to enable the use of federal Medicaid (Medi-Cal in California) financial participation with a 50% match. Yet California lags behind the nation in implementing a peer support specialist certification program.

THE VALUE OF PEER SUPPORT SERVICES

Studies demonstrate that use of peer support specialists in a comprehensive mental health or substance disorder treatment program helps reduce client hospitalizations, improve client functioning, increase client satisfaction, alleviate depression and other symptoms, and diversify the mental health workforce. Often, peers serve as the first and sustained point of contact for people living with mental illness and assist them with the treatment they need at the earliest moment.

Peer support can divert people from emergency services and ensure patients receive a continuum of care, saving substantial costs of treatment and improving health outcomes. Research shows that peers contribute to the ability of people with mental illness and substance abuse to obtain education and employment, contributing to the California economy rather than depending on social safety nets alone.

Prestigious organizations such as CMS, SAMSHA, and the Institute of Medicine among many others have identified peer delivered services offered through a certified peer specialists as being valuable services. While increasing consumer wellness, the use of peer specialists is decreasing costs. Data shows a clear return on investment when peers are part of the mental health system.

THIS BILL

SB 803 establishes a statewide certification program for peer support specialists and provides the structure needed to maximize the federal match for peer services under Medi-Cal. The program defines the range of responsibilities and practice guidelines for peer support specialists, specifies required training and continuing education requirements, determines clinical supervision requirements, and establishes a code of ethics and processes for revocation of certification.

FOR MORE INFORMATION

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SPONSORS

California Association of Mental Health Peer Run Organizations (CAMHPRO)
County Behavioral Health Directors Association of California (CBHDA)
County of Los Angeles Board of Supervisors
Steinberg Institute

SB 854 - SENATOR JIM BEALL

Mental Health: Access to SUD Treatment

Principal co-authors Senator Wiener, Assemblymembers Aguiar-Curry, Arambula, and Chiu
Co-authors Senators Hill and Glazer, Assemblymember Maienschein and Wicks

Issue

Federal and state laws are in place to ensure Californians struggling with mental illness, including substance use disorders, can receive appropriate treatment when they most need it. But Californians in crisis often face barriers and delays when they seek help for substance use disorders. Medication-assisted treatment, or MAT, is an evidence-based treatment for substance use disorders. Even when a doctor judges that a patient is in need of MAT, patients often go without treatment because of prior authorization and step therapy requirements. SB 854 removes these barriers, allowing a doctor to provide timely and appropriate treatment.

BACKGROUND

Overdose and suicide rates are rising at a terrifying rate. In California alone, there were an estimated 2,012 opioid-related deaths in 2016. The rate of fentanyl-related deaths more than quadrupled between 2011 and 2017, according to the Department of Public Health.

The FDA has approved and indicated 11 prescription-only medications for treatment of three SUDS: opioid use disorder (OUD), alcohol use disorder (AUD), and/or tobacco use disorder (TUD). MAT is the use of these medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help people to sustain recovery.

The Surgeon General's 2016 report, Facing Addiction in America, says MAT "is a highly effective treatment option for individuals with alcohol and opioid use disorders. Studies have repeatedly demonstrated the efficacy of MAT at reducing illicit drug use and overdose deaths, improving retention in treatment, and reducing HIV transmission."

A 2017 California Society of Addiction Medicine (CSAM) survey of its membership showed significant concern about the administrative barriers created by authorization requirements. Fifty-six percent of respondents found it difficult to access MAT for patients new to treatment due to insurance barriers, and 46 percent had difficulty getting approval for maintenance treatment.

41 percent of physicians experienced situations where patients went without treatment due to authorization delays. Often one to two hours of employee time was required per patient to collect documentation for clinical justifications, drug screens, and counseling, and to call the health plan (which was required more than half the time). When a person struggling with addiction is willing to work with their doctor and try medication- we need to jump at that chance.

THIS BILL

SB 854 prohibits a mental health plan or insurer from imposing any prior authorization requirements or any step therapy requirements before authorizing coverage for FDA-approved prescriptions. It will also place the FDA-approved medications for treatment of substance use disorders on the lowest cost-sharing tier.

SPONSORS

The Kennedy Forum
Steinberg Institute

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Senator Scott Wiener, 11th Senate District

Senate Bill XX – Mental Health as a Medical Necessity

SUMMARY

Senate Bill XX strengthens the California Parity Act to require that insurers cover medically necessary treatment for all mental health and substance use disorders (MH/SUD), not just emergency care.

BACKGROUND

The California Parity Act was a groundbreaking piece of legislation enacted in 1999. It requires that, for nine mental illnesses and serious emotional disturbances of a child, health plans must cover them as medically necessary treatment. Parity in health care is fundamentally grounded in ensuring mental health and substance use disorders are treated at the same level, frequency, and availability as other medical and surgical services. Unfortunately, however, there is a major flaw in the law: the California Parity Act applies neither to all mental health conditions nor to substance use disorders. This omission leaves out the lion's share of mental health conditions.

Additionally, the lack of a definition for "medically necessary treatment" has created ambiguity. While several court decisions – *Harlick v. Blue Shield of California* and *Rea v. Blue Shield of California* – have interpreted this phrase broadly, there remains a need to establish a definition with the best clinical standards to ensure Californians are able to obtain the mental health and substance use treatment services they need.

Wit v. United Behavioral Health found that United Behavioral Health created deeply flawed level of care criteria that wrongly denied needed coverage. The court held that United Behavioral Health's criteria were inconsistent with generally accepted standards of mental health and addiction care. The use of such flawed proprietary criteria is common. In many cases, these criteria have not been externally validated, and are not publically available or even fully accessible to patients.

California is currently experiencing a mental health and substance use crisis. Expanding access to MH/SUD services must be one of the highest priorities for California. Homelessness, housing, education and criminal justice challenges are exacerbated when our health care system doesn't provide adequate mental health and substance use disorder treatment services to those who desperately need it.

SOLUTION

Senate Bill XX defines MH/SUD services as "medically necessary treatment". This treats MH/SUD as a covered service that aligns with what is recommended by the treating provider, furnished in sufficient amount, discretion, and scope to meet the patient's comprehensive needs, and consistent with generally accepted standards of practice. It also prohibits limiting benefits or coverage for chronic conditions to short-term or acute treatment.

SB XX requires plans, for level of care determinations, to use the non-profit, clinical professional association criteria identified in the *Wit* case as consistent with generally accepted standards of mental health and addiction care, as well as specified criteria for autism spectrum disorder. It requires plans to meet requirements relating to the implementation and usage of these criteria.

SB XX states that if required services are not available, health plans must immediately cover services out-of-network at in-network rates. It also continues to allow plans to impose geographic restrictions on care, but clarifies only when service areas within timeliness standards. SB XX also prohibits plans from denying medically necessary services on the basis that they should be or could be covered by a public entitlement program.

SUPPORT

- The Kennedy Forum
- Steinberg Institute

FOR MORE INFORMATION

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