Commission Packet

Commission Meeting
September 26, 2019

MHSOAC
1325 J Street Sacramento, CA 95814

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

September 26, 2019
9:00 AM – 3:45 PM

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment period. Generally, an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC will also accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov.

All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

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Khatera Tamplen
Chair

AGENDA
September 26, 2019

Lynne Ashbeck
Vice Chair

Approximate Times

9:00 AM **Convene and Welcome**
Chair Khatera Tamplen will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, Kylene Hashimoto. Roll call will be taken.

9:05 AM **Announcements**

9:10 AM **Moment of Silence and Remembrance of Rusty Selix**

9:20 AM **Moment of Silence and Remembrance of Commissioner Emeritus Larry Poaster**

9:30 AM **Consumer/Family Voice**
Irene Wei will open the Commission meeting with a story of recovery and resilience.

9:50 AM **Action**
1: Approve August 22, 2019 MHSOAC Meeting Minutes.
The Commission will consider approval of the minutes from the August 22, 2019 meeting.

- Public Comment
- Vote

9:55 AM **Information**
2: Department of Health Care Services
Presenter:

- Kelly Pfeifer, MD, Deputy Director, Mental Health and Substance Use Disorder Services

Deputy Director Pfeifer will provide an overview of the projects underway with the Mental Health and Substance Use Disorder Services Division at the Department of Health Care Services.

10:35 AM **Action**

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.]

3: Sutter-Yuba County Innovation Plan: Approval of $5,939,288 in Innovation funding to support Sutter-Yuba Innovative and Consistent Application of Resources and Engagement (iCARE) Innovation Plan.

- Public Comment
- Vote

10:50 AM **Action**

4: Glenn County System-wide Mental Health Assessment and Response Treatment Team (SMART)

Presenters:

- Detective Greg Felton, Glenn County Sheriff's Office
- Lisa Cull, LMFT, Clinician, Glenn County Health and Human Services
- Amy Lindsey, LMFT, Deputy Director, Glenn County Behavioral Health
- Nancy Callahan, Ph.D., Consultant, I.D.E.A. Consulting

The Commission will hear about the results of Glenn County System-wide Mental Health Assessment and Response Treatment Team (SMART) Innovation Project that was approved by the Commission in 2014. SMART is a collaborative multi-agency team that responds quickly and efficiently to critical school incidents such as school threats, suicidal behavior, violence, and bullying. The Commission will consider opportunities to explore collaborative partnerships to expand this model.

- Public Comment
- Vote

11:50 AM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

12:05 PM **Lunch Break**

1:30 PM **Action**

5: Election of the MHSOAC Chair and Vice-Chair for 2020

Facilitator:

- Filomena Yeroshek, Chief Counsel

Nominations for Chair and Vice-Chair for 2020 will be entertained and the Commission will vote on the nominations and elect the Chair and Vice-Chair.

- Public Comment
- Vote

2:10 PM **Action**

6: MHSOAC Draft Strategic Plan

Presenters:

- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig-Niclai, MA, Vice President of Evaluation

The Commission will be presented with the draft MHSOAC Strategic Plan.

- Public Comment
- Vote

3:10 PM **Information**

7: 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
- Vote

3:30 PM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

3:45 PM **Adjourn**

AGENDA ITEM 1

Action

September 26, 2019 Commission Meeting

Approve August 22, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the August 22, 2019 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (1): (1) August 22, 2019 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the August 22, 2019 meeting minutes.

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
August 22, 2019

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

Additional Public Locations

State Capitol Room 2082
Sacramento, CA 95814

6401 Linda Vista Road
San Diego, Ca 92111

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Mayra Alvarez
Reneeta Anthony
Ken Berrick
John Boyd, Psy.D.
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Lynne Ashbeck, Vice Chair
Senator Jim Beall
Sheriff Bill Brown
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 Operations

[Note: Agenda Item 6 was taken out of order. These minutes reflect this Agenda Item as taken in chronological order and not as listed on the agenda.]

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

The next Commission meeting will be held in Sacramento on September 26th.

The next Early Psychosis Intervention Advisory Committee meeting will be held in Sacramento on August 29th from 10:00 a.m. to 3:30 p.m. The Committee will continue its discussion on how to allocate available funding to support early detection and intervention efforts around the state.

Chair Tamplen introduced Dr. Kelly Phifer, the new Deputy Director of Mental Health and Substance Use Disorder Services for the Department of Health Care Services (DHCS). She welcomed Dr. Phifer and stated she looked forward to working with Dr. Phifer in the Commission's continued effort to improve mental health services and outcomes for all Californians.

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. Amanda Simon introduced herself.

New Personnel

Dawnte Early, Ph.D., Chief, Research and Evaluation, introduced new staff members Xing Shen, Ph.D., Research Scientist III; Latonya Harris, Ph.D., Research Scientist III; and Lillian Borunda, Graduate Research Assistant.

Tom Orrock, Chief, Commission Operations and Grants, introduced new staff member Michele Nottingham, Health Program Specialist I.

Sharmil Shah, Psy.D., Chief, Program Operations, introduced new staff member Jonathan Hernandez, Student Assistant.

Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations, introduced new UCLA Fellow Ish Bhalla.

Consumer/Family Voice

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

Juan Acosta shared the story of identifying as a gay male, which brought him a lot of attention but also made him a target for bullying and harassment during grade school, which led to the development of depression at a very young age and eating to cope with his feelings. He shared about encountering mentors in his school counselors who gave him a chance to show who he really was and not just the labels that defined him. He saw counselors that helped him lift himself from the dark space he was in and he was able to lose 100 pounds. He became passionate about community service, which made him feel that he was doing something to create change. He pledged to be a vehicle for the change he wants to see in the world.

Questions and Discussion

Commissioner Anthony thanked Mr. Acosta for reminding everyone of individual struggle and success.

Chair Tamplen thanked Mr. Acosta for his work on the Commission's Youth Innovation Project.

ACTION

1: **Approve May 23, 2019, June 10, 2019, and July 25, 2019, MHSOAC Meeting Minutes**

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

The Commission approves the May 23, 2019, Meeting Minutes as presented.

Motion carried 7 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Bunch, Danovitch, Mitchell, Wooton, and Chair Tamplen.

The following Commissioners abstained: Commissioners Alvarez and Gordon.

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

The Commission approves the June 10, 2019, Meeting Minutes as presented.

Motion carried 7 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Bunch, Danovitch, and Gordon.

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

The Commission approves the July 25, 2019, Meeting Minutes as presented.

Motion carried 5 yes, 0 no, and 5 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Anthony, Berrick, Bunch, Madrigal-Weiss, and Chair Tamplen.

The following Commissioners abstained: Commissioners Alvarez, Danovitch, Gordon, Mitchell, and Wooton.

ACTION

2: <u>Alameda County Innovation Plan</u>

Presenters:

- Tracy Hazelton, MPH, Division Director MHSA, Alameda County Behavioral Health
- Mary Skinner, J.D., Innovations Coordinator, MHSA, Alameda County Behavioral Health
- Robert Ratner, M.D., MPH, Housing Services Director, Alameda County Health Care Services Agency – Behavioral Health
- Margot Dashiell, M.A., M.S., Vice President, NAMI-East Bay, and Facilitator, the African American Family Support Group

Chair Tamplen asked Chair Emeritus Commissioner Tina Wooton to facilitate this agenda item.

Chair Tamplen recused herself from the discussion and decision-making on this agenda item and left the room pursuant to Commission policy.

The presenters provided an overview, with a slide presentation, of the need, proposed project to address the need, innovative components, evaluation, budget, and sustainability of the proposed Innovation project.

Commissioner Questions and Discussion

Commissioner Anthony stated she was involved in establishing various types of housing in Fresno County. One of the things that was found to be extremely important was bank funding. She emphasized including the involvement of banks for the overall health of the plan.

Commissioner Berrick asked for clarity on the governance structure for the proposed project.

Robert Ratner, M.D., MPH, Housing Services Director, Alameda County Health Care Services Agency – Behavioral Health, stated the governance structure will be dependent on the partner that is selected. He summarized possible options and stated

the county is not planning to do a Joint Powers Authority (JPA) agreement for this project but will create more of a traditional non-profit.

Commissioner Berrick asked if the county worries about asset accumulation.

Dr. Ratner stated he thinks about how assets are managed over time. The core area of success for land trusts that have made a large impact are the board of directors and the leadership over time. One of the unique things about this project is the partnership between the public sector and the nonprofit organization to create checks and balances.

Commissioner Mitchell stated she loved the proposed project because the need is so great. This is a monumental effort to address the homeless population. She thanked the county for including the consumer voice in their presentation.

Commissioner Mitchell asked when beds will be available and how individuals with no voice can be included in the project.

Dr. Ratner stated the plan is to acquire two properties and get them up and running in approximately two years.

Margot Dashiell, M.A., M.S., Vice President, National Alliance on Mental Illness (NAMI) East Bay, and Facilitator, the African American Family Support Group, added that the plan is to begin with small projects in that second year and build from there.

Commissioner Berrick stated that it was not until now that he realized the Innovation project includes buying property. After consulting with counsel, he recused himself from the discussion and decision-making on this agenda item and left the room pursuant to Commission policy.

Commissioner Gordon asked how the logistics and financials would work. There are five existing Board and Care that will be coming off the market. He asked if this project could be used to turn that around.

Dr. Ratner stated he personally has been involved with the closure of six licensed Board and Care. In all those situations, the county had been subsidizing individuals to live at those sites. He stated not everyone who is selling property is motivated by profit. The owners approached the county saying they would be happy to sell the property to the county at a low rate, but the county had no structure or ability to acquire those properties. The county has set aside $5 million to invest in the proposed project's startup. The difference is now the county has the ability to invest in properties and can purchase Board and Care facilities as they go up for sale.

Amanda Simon stated she likes that the proposal not only addresses the needs of the county but also sets up a model for other counties to use. Solvency over time is important. She asked if there are other criteria to determine who can participate in the project other than individuals with a serious mental illness.

Dr. Ratner stated one of the things about housing financing is that the money often drives who can be served. To draw in funding, the county will need to meet the funder's requirements. The U.S. Department of Housing and Urban Development (HUD) requires the county to keep a list of individuals experiencing homelessness who are interested in receiving support. A prioritization process has been created to assess the

level of need. There are currently over 7,000 individuals on that list. The board of directors will ensure that the county will focus on individuals with the greatest barriers to get into housing.

Commissioner Alvarez stated the need for immediate return on these investments. This investment will, hopefully, change the way that business in done in the future. She asked staff about the trend in closure of licensed Board and Care facilities in other counties statewide. She asked if those trends can be captured so county leadership can begin to plan early on how this model can potentially evolve in other communities.

Public Comment

Virginia Hall, Public Policy and Education Committee, Alameda County Behavioral Health Care Services, Pool of Consumer Champions (POCC), spoke in support of the proposed project.

Chikwanda Chabala, Alameda County Behavioral Health, POCC, spoke in support of the proposed project.

Mandy Taylor, California LGBT Health and Human Services Network, #Out4MentalHealth project, spoke in support of the proposed project.

Kathleen Sikora, East Bay Supportive Housing Collaborative, spoke in support of the proposed project.

Mary Hogden, Alameda County Behavioral Health Care Services, POCC Manager, spoke in support of the proposed project.

Gordon Reed, Alameda County Behavioral Health Care Services, POCC, spoke in support of the proposed project.

Paulette Franklin, POCC, spoke in support of the proposed project.

Curtis Reed, Jr., POCC, spoke in support of the proposed project.

Poshi Walker, LGBTQ Program Director, Mental Health American of Northern California (NorCal MHA), Co-Director, #Out4MentalHealth project, spoke in support of the proposed project.

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

The Commission approves Alameda County's Innovation plan as follows.

> *Name: Supportive Housing Community Land Trust (CLA)*
>
> *Amount: $6,171,599*
>
> *Project Length: Five (5) Years*

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Boyd, Bunch, Danovitch, Gordon, Mitchell, and Wooton.

Chair Tamplen and Commissioner Berrick rejoined the Commissioners at the dais.

ACTION

3: Awarding of the Transition Age Youth Stakeholder Contract

Presenters:

- Tom Orrock, Chief of Grants, MHSOAC
- Michele Nottingham, Health Program Specialist I, MHSOAC

Chair Tamplen stated the Commission will consider awarding a contract for stakeholder advocacy in the amount of $1,840,000 to the highest scoring applicant for the Transition Age Youth Stakeholder Request for Proposal. She asked staff to present this agenda item.

Tom Orrock, Chief of Grants, MHSOAC, shared the results of the most recent Request for Proposals (RFP) to provide advocacy, outreach, training, and education on behalf of transition age youth (TAY). He provided an overview, with a slide presentation, of the timeline, background, and requirements of the RFP.

Michele Nottingham, Health Program Specialist I, MHSOAC, continued the slide presentation and discussed the RFP responses, evaluation of the proposals, and announced the highest-scoring proposal. The highest-scoring proposal was submitted by the California Youth Empowerment Network (CAYEN), a program of Mental Health America of California (MHAC).

Commissioner Gordon asked whether staff could share the key personnel listed on the proposal.

Tom Orrock stated he did not have that information but could obtain it.

Public Comment

No members of the public addressed the Commission.

Action: Commissioner Wooton made a motion, seconded by Commissioner Gordon, that the MHSOAC:

- *Authorizes the Executive Director to issue a "Notice of Intent to Award Contract" to the highest scoring proposer: California Youth Empowerment Network (CAYEN), a program of Mental Health America of California (MHAC).*
- *Establishes August 29, 2019, as the deadline for unsuccessful bidders to file an "Intent to Protest" and September 6, 2019, as the deadline to file a letter of protest consistent with the requirements set forth in the RFP.*
- *Directs the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.*
- *Authorizes the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.*

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Bunch, Gordon, Mitchell, Wooton, and Chair Tamplen.

ACTION

4: MHSOAC Conflict of Interest Code

Presenter:

- Filomena Yeroshek, Chief Counsel, MHSOAC

Chair Tamplen stated the Commission will consider approving proposed amendments to the MHSOAC's Conflict of Interest Code needed because of new staffing classifications. She asked Chief Counsel to present this agenda item.

Filomena Yeroshek, Chief Counsel, MHSOAC, provided an overview, with a slide presentation, of the background, draft amendments, and next steps of the MHSOAC Conflict of Interest Code.

Commissioner Questions and Discussion

Commissioner Mitchell asked what would happen if the Commission voted against the proposed amendments.

Ms. Yeroshek stated she would ask if there are changes the Commission would like to make.

Public Comment

No members of the public addressed the Commission.

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

The MHSOAC adopts the draft amendments to the conflict of interest code and authorizes the Executive Director to take the necessary steps to begin the rulemaking process and 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 Alvarez, Anthony, Berrick, Bunch, Danovitch, Gordon, Mitchell, Wooton, and Chair Tamplen.

GENERAL PUBLIC COMMENT

Mikayla Johnson, consumer and advocate, shared her story of living with mental illness and how she is working with children with special needs.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), was asked by Mental Health America of California to thank the Commission and staff for the hard work they put into the TAY proposal. The speaker stated, if all goes forward, they look forward to working with everyone.

Stacie Hiramoto stated the majority of the stakeholder advocacy grants will be going through the RFP process again next year. The speaker stated the hope that Commission staff will arrange for the public to weigh in before the RFP is released and not just talk to the current stakeholder contractors.

Katherine Ferry, NorCal MHA, was asked to comment on behalf of NorCal MHA's Access California Client Stakeholder Program. Access California recommends that the Commission provide ongoing guidance and recommendations to counties regarding the MHSA's mandates for county staff and community training related to the MHSA, meaningful stakeholder involvement in the community process, integration of general standards of the MHSA, and the effectiveness of county stakeholder outreach and engagement. The speaker suggested standardization and education in how to do better community planning.

Poshi Walker stated Access California is convening a statewide event tomorrow in Los Angeles. The speaker thanked the Commission for reinstating public comment prior to the lunch break. The speaker stated the stakeholder contractors get together in quarterly Stakeholder Collaboration meetings. At the recent meeting, a request was made to find ways to better work with the Commission to be able to act as a resource and advisory group to the Commission. The speaker asked Commissioners for ideas of how that can happen. Stakeholder contractors are subject matter experts who can be used as resources to the Commission.

Amanda Simon stated her favorite parts of the meeting were hearing the story of recovery and resilience at the beginning of the meeting and the public comment periods. It is inspiring to hear the stories. They show how self-actualization needs to be achieved before mental health needs can be worked on. It is also inspiring to see how people can work together from diverse backgrounds to initiate change in the mental health system.

LUNCH BREAK

Chair Tamplen stated she will not return after lunch due to family business. She asked Chair Emeritus Commissioner Tina Wooton to facilitate the afternoon agenda.

[Note: Agenda Item 5 was heard after Agenda Item 6.]

ACTION

6: <u>MHSOAC Budget Overview</u>

Presenter:

- Norma Pate, Deputy Director, MHSOAC

Commissioner Wooton stated the Commission will consider approval of its final Fiscal Year 2018-19 Operations Budget and its proposed Fiscal Year 2019-20 Operations Budget. She asked staff to present this agenda item.

Norma Pate, Deputy Director, MHSOAC, provided an overview, with a slide presentation, of the expenditures for Fiscal Year (FY) 2018-19, and the proposed budget for FY 2019-20.

Commissioner Questions and Discussion

Commissioner Anthony stated she attended the hearings yesterday and heard staff testify. She stated staff has a complex job. She recognized the effort that Executive Director Ewing and his staff have put forward in order to do the work that is necessary.

Executive Director Ewing referred to Slide 4, the budget for FY 2019-20, and noted that the line item of $50 million for the Mental Health Services for Students Act of 2019, which is marked for future approval, may be broken up over years.

Commissioner Mitchell asked if the Mental Health Services for Students Act of 2019 funds include grades 0-12 or if it includes college age.

Executive Director Ewing stated he has a handout that will be distributed during the Executive Director Report Out with more information on that Act. He stated the law stipulates that the Commission will fund partnerships that include the county behavioral health department, a school district, and either a charter school or county office of education. The partnership can be broader but must consist of at least those three entities. The funds will be used based on the priorities of the community.

Commissioner Anthony stated members of yesterday's hearing indicated they would like to be able to draw upon the monies provided by the MHSA for emergencies that they experience in their communities. She noted that monies were drawn upon during the fiscal downturn of 2005 through 2008 and those MHSA funds have not yet been paid back. MHSA funds are for mental health services, not to solve all the financial issues that a community may suffer during an emergency.

Public Comment

Stacie Hiramoto did not have objections or concerns with the budget as presented but asked that the Commission develop guidelines for the awards of grants under $100,000 that the Executive Director may execute by consulting with the Chair. The speaker requested that, when grants are awarded, the public be made aware by both publishing on the web and announcing at meetings to keep stakeholders informed.

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

The MHSOAC approves the final FY 2018-19 expenditures and the proposed FY 2019-20 budget as presented.

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

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

ACTION

5: Legislative and Budgetary Priorities

Presenter:

- Toby Ewing, Ph.D., Executive Director

Commissioner Wooton stated the Commission will consider legislative and budgetary priorities, including consideration of AB 480 (Salas): Mental Health: Older Adults and SB 665 (Umberg): Mental Health Services Fund: County Jails. She asked staff to present this agenda item.

AB 480

Executive Director Ewing reviewed the summary and background of AB 480, which was included in the Staff Memo in the meeting packet. He introduced Erik Turner, with Assembly Member Salas's office.

Mr. Turner updated the Commission on the purpose, goals, and current status of AB 480. The bill is currently pending on the suspense file in the Senate Appropriations Committee.

Commissioner Questions and Discussion

Commissioner Anthony asked how AB 480 is different from what has already been funded.

Mr. Turner stated amendments are being explored in the Senate Appropriations Committee to reduce redundancies and overlap with current services. Ultimately, the bill seeks to increase the reporting of outcome measurements that the UCLA study found to be lacking for seniors.

Amanda Simon stated the concern that the bill serves older adults who grew up in an entirely different time than the youth currently being served. Naturally, there will be a lot of stigma that will prohibit the progress. She asked if the bill addresses stigma in older adults.

Mr. Turner stated one of the intensions of the bill is to reduce the stigma. The hope is that, by increasing the focus and increasing the data on older adults who are receiving services, it can improve outreach and service integration.

Commissioner Gordon asked if the DHCS supports AB 480.

Mr. Turner stated they do not have an official position on the bill at this time. He stated he will meet with them next week to discuss the bill.

Commissioner Gordon stated he, like Commissioner Anthony, was concerned about requiring an agency administrator to determine the agenda as compared to setting out the requirements for the agency to perform.

Mr. Turner stated that is being discussed in the amendment process.

Commissioner Alvarez asked how the bill relates to the Master Plan for Aging and if the timeline could wait to determine the priorities that will be set out by the Master Plan.

Mr. Turner stated it is currently being discussed with the administration to see if delayed implementation would be a possibility so the Master Plan for Aging can be used to inform AB 480 or vice versa. Those discussions are ongoing.

<u>SB 665</u>

Executive Director Ewing reviewed the summary and background of SB 665, which was included in the Staff Memo in the meeting packet.

Commissioner Questions

Commissioner Gordon stated, since the criminal justice realignment, many more incarcerated persons are being sent to county jails who would have been in state prison. The county jails now have half the population of state prisons. He stated his concern that the population that was prohibited from being funded by the MHSA by state action will be moved to the county level, and about the drain on local MHSA funding. He stated the need for a separate, additional funding source to take care of this issue.

Commissioner Danovitch stated he was open, in principle, to the notion of supporting the mental health needs of the community by delivering services while individuals are incarcerated. One of the many problems is that there are services in jail and in the community but there is a tremendous discontinuity between the two. There are dislocation and disruption of services as individuals move between the community and jail. If the Commission was to look at a way of delivering resources to this population that address needs in jail, it should look for mechanisms that could address that disruptive, poorly integrated mechanism so that there could be continuity of care across different areas.

Amy Jenkins, Orange County Board of Supervisors, the sponsors of this bill, stated she agreed with the concern about the disconnect and gaps in natural services to this population.

Commissioner Danovitch stated he not only was concerned about adding services but also about coordination so that the community standard of care and continuity is supported as individuals move in and out of the community.

Commissioner Bunch stated that this bill closes the gap in services because now people are not receiving services in jail.

Ms. Jenkins stated the lack of a continuum of care is the reason the Orange County Board of Supervisors is sponsoring SB 665. Providing services in jail could reduce recidivism and prevent that gap in service.

Commissioner Berrick stated he has spoken to many individuals about this bill since the last Commission meeting. He stated there are serious policy issues not the least of which is the federal lock-out for mental health services in locked environments. The real policy issue is that the federal government does not support treatment of individuals who are incarcerated just because they are incarcerated. SB 665 will not solve this issue. Energies would be better spent focusing on the real policy problem. Also, the

MHSA was never intended to do this. He stated he is strongly opposed to SB 665 as currently written.

Amanda Simon asked why the MHSA forbids felons from receiving services.

Ms. Jenkins stated felons are specifically exempted from the bill because the MHSA is clear that funds could not be used for incarcerated individuals in prisons but is silent on county jail facilities.

Public Comment

Jane Adcock, Executive Officer, California Behavioral Health Planning Council (CBHPC), spoke in support of AB 480 and in strong opposition to SB 665. SB 665 is not in alignment with the spirit of the MHSA and other dollars are used to provide those services. The CBHPC recommends that there be joint authority and perhaps a match requirement.

Poshi Walker stated NorCal MHA and the #Out4MentalHealth program strongly oppose SB 665. The speaker echoed Commissioner Berrick's comments. The fact that the MHSA is silent on county jail facilities is unintended. There are many things the Constitution of the United States is silent on. Things are not prohibited or allowed just because the Constitution is silent. The MHSA only supports voluntary services. Saying individuals will receive services "while they are a captive audience" is a huge problem. It goes against the spirit of the MHSA just using those words. The fact that funding cannot be found for it does not mean that the MHSA is to solve that problem.

Danny Offer, National Alliance on Mental Illness (NAMI) California, spoke in opposition to SB 665. He echoed the previous speakers' comments.

Wesley Mukoyama, Santa Clara County Behavioral Health Board, stated the need for a separate older adult division. Jail is not prison. Individuals in jail are still innocent; they have not gone to court. Individuals in jail need help while they are in jail and when they get out. There are more programs in prisons than in jails. The speaker agreed that the sheriff's department should have funds of its own.

Pam Hawkins, United Parents, spoke in strong opposition to SB 665. The main tenet of MHSA was to provide treatment in the community prior to any incarceration. Also, there are other funds already available.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of AB 480 and in strong opposition to SB 665. The MHSA is to be used for community services, not for individuals who are incarcerated or in institutions.

Steve Leoni, consumer and advocate, spoke in opposition to SB 665. County jail facilities were not mentioned in the MHSA because it was understood. The speaker read from Welfare and Institutions Code section 5801.5 to support his opposition of SB 665. The MHSA fund needs to be protected.

Commissioner Discussion

Executive Director Ewing stated that the Commission had options in dealing with the bills, including directing staff to work with the author's office regarding the Commission's concerns. SB 665 is still in the Senate and is not likely to move out this year. The Commission has not taken an oppose position before. The tradition has been to give guidance and make stuff happen verses opposing a bill.

Commissioner Berrick stated that he agrees with what the Commission has done in the past, but this issue is at the core of the MHSA and he feels very strongly about opposing it.

Commissioner Anthony stated that counties could possibly use Innovation funds for a pilot project.

Commissioner Gordon stated that using Innovation funds creates a risk of slippery slope.

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

The MHSOAC opposes SB 665.

Motion carried 5 yes, 1 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Gordon, and Wooton.

The following Commissioner voted "No": Commissioner Madrigal-Weiss.

The following Commissioners abstained: Commissioners Bunch and Mitchell.

Commissioner Discussion

Commissioner Alvarez asked to table the vote on AB 480 and suggested the author's office connect with the new Deputy Director of the DHCS.

Commissioner Alvarez asked staff to research opportunities to support the California Department of Social Services (CDSS) to ensure that the continuum of services is culturally competent and as high quality as can be for immigrants and refugees.

Commissioner Anthony spoke in support of AB 1126, the approval of the MHSA Technical Assistance Centers or Clearinghouses.

Commissioner Berrick stated he did not have specific legislation for staff to track but stated a tremendous start has been made with the budget allocation for integrated mental health services and in tracking the bill on restructuring the ability to use mental health funding more flexibly for children and families. He suggested the priorities of continuing to maintain that and thinking about next steps.

Commissioner Wooton suggested a focus on consumer and family member employment and asked staff to research the current number of peers employed in the

mental health system and evidence-based practices that are already in place in California.

Executive Director Ewing stated the Commission pursued legislation a couple of years ago to authorize the Employment Development Department (EDD) to share data with the Commission to begin to track employment outcomes. Staff has met with the EDD to understand the process needed to access that information. The intent is to facilitate a conversation with counties and stakeholders to develop a methodology to track employment outcomes.

Executive Director Ewing stated, that in addition, Chair Tamplen has been facilitating a series of conversations with consumers, with support from the staff, about how the Commission can support peer engagement above and beyond the peer certification bill including doing an economic analysis of cost avoidance, cost savings, and return on investment of peer-run programs. Staff will be presenting at the 2019 International Association of Peer Supporters Conference in San Diego next month. A set of options will be developed of ways in which the Commission might further the conversation around the role of peers in the mental health system.

Commissioner Wooton reminded staff that there are individuals who volunteer or only work in extra help positions that may not be denoted at the EDD. She asked staff to dig deeper to include those individuals.

Commissioner Alvarez asked for an update on the 2020 plan for the change from juvenile justice coming into the California Health and Human Services Agency (CHHS) and the opportunities to engage in that important shift in the approach to juvenile justice.

Commissioner Alvarez asked, regarding schools and mental health, if there is an opportunity to explore further upstream prevention and early intervention with children and to start thinking about early childhood care facilities and early learning centers as an opportunity to integrate mental health and what that would look like. These are exploratory areas for policy and legislative priorities that may align well with the Governor's priority where mental health and behavioral health can be integrated in other settings.

Executive Director Ewing responded to Commissioners Alvarez and Mitchell's concerns raised about the age timeframes and who is eligible. He stated staff needs to better understand what the parameters are under the law, but the Commission has discretion in how to create priorities under the Mental Health Services for Students Act of 2019. Staff also has an ongoing project, led by Commissioner Madrigal-Weiss, on prevention and early intervention. There is currently a deficit of understanding and strategy in prevention and mental health relative to the public health approach to things such as measles or cardiac health care.

Executive Director Ewing stated this creates an opportunity for the Commission to explore what up-stream looks like and how it might be pursued. The legislation directs the Commission to create a framework and strategy for county prevention and early intervention investments. That is the richest opportunity for the Commission to shape how resources are available to those kinds of activities.

Commissioner Alvarez stated the DHCS put out a request for comment around value-based purchasing and behavioral health integration, which is an important sign of commitment to how the health system can better integrate behavioral health. She asked how that relates to the work the Commission does to evaluate county Innovation proposals, enter into discussions, and provide technical assistance to better understand how the overall health care system is prioritizing behavioral health.

Executive Director Ewing stated there are opportunities staff has pursued in the past and is currently pursuing.

INFORMATION

7: Executive Director Report Out

Presenter:

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

Executive Director Ewing presented his report as follows:

Budget

Modifications to the budget will occur in the next couple of weeks to secure additional office space within the same building.

Project Updates

Fiscal Reporting Tool

The Commission's transparency work has received significant attention. Staff is struggling to update that work because of changes in reporting requirements coming out of the DHCS. Staff has talked to the Chair about better understanding the rationale for those changes and how the Commission might negotiate a strategy to give the Legislature and the public an ongoing understanding of unspent funds, which is one of the key questions that led to the Oversight Hearing held yesterday. The primary questions coming out of that hearing were if the mental health system is working, and how to know if it is working. Current evidence is that it is not.

Innovation

Changes in the law now authorize the Commission to set the timeframe for Innovation plans. Under regulatory authority, the Commission has set that window at five years. The question is if the regulations need to change before the Commission can approve Innovation plans for over five-years. This is important because the reversion rules for Innovation dollars have changed. Prior to this change in the law, dollars reverted in three years from the year they were received and five years for small counties.

The Legislature now recognizes that innovation is challenging, and proposals are often creative so they have mandated that it will now be the Commission's approval date that will determine the reversion deadline or the original three- or five-year period, whichever is longer. Dollars are sheltered from reversion under the terms of the Commission's approval.

This also creates uncertainties in terms of reversion, particularly around the issue of what happens when a county has an approved Innovation plan that goes beyond the three- or five-year window where the funding is naturally protected from reversion and a county chooses to end that project early. The informal interpretation of the law is that, if a county amends a plan and the Commission approves a different Innovation plan, the funding could move from the previously-approved Innovation into a newly-approved Innovation.

The concern is, without that interpretation, the countries that recognize early that an Innovation is not working and shut the program down will lose the funding. The statutory authority for making that determination ultimately falls under the DHCS. This has yet to come up because the trigger for reversion has recently become the project length instead of the set reversion timeframe.

Innovation Incubator

Ish Bhalla, UCLA Fellow, updated the Commission on the big-picture plan for the Innovation Incubator. The remaining $2.5 million needs to be encumbered by the end of the 2019-20 FY. Planning has begun for this now. The thought is to use these funds to work with counties to support multi-county collaborative ideas.

Youth Innovation Project

The Youth Innovation Project has been moving forward. The leadership group has identified school mental health as a theme with opportunities to infuse the perspective of youth and TAY into that effort. Representatives of the youth leadership group presented to county behavioral health directors and coordinators. The directors and coordinators asked that the youth leadership group partner with county youth leadership groups to do some regional ideation conversations around how Innovations might be designed for that.

One county has committed to fund any innovation that comes out of this process and other counties have shown tremendous interest in this. Many county directors and coordinators at this meeting recognized that they do not do a good job of engaging young people. They suggested that an additional benefit of this process is, in partnership with counties that do have strong youth engagement strategies, that the Commission could develop a guidebook of strategies that all counties could pursue to ensure that there is a robust, healthy, strong youth voice in their community planning process. Commissioners will be invited to participate in the upcoming ideation labs.

Commissioner Anthony stated the Client and Family Leadership Committee will be working with staff to invite someone to speak at the September Committee meeting regarding promising practices of engaging communities. The Committee wants to develop guidelines or a toolkit to assist counties in engaging populations and to learn what works in counties and what are promising practices statewide and nationwide on engagement.

Listening Sessions

Listening sessions will be conducted on the Schools and Mental Health, Early Psychosis, and Integrated Youth Services Drop-in Projects over the next few months with the intent that proposals for how to allocate the funding will be presented at future Commission meetings.

State Suicide Prevention Plan

There was a State Suicide Prevention Plan meeting in Eureka on August 15th. Another meeting is planned to be held in Sacramento on the August 28th.

Rules of Procedure

The proposed changes to the Rules of Procedure will be presented at a future Commission meeting.

Stakeholder Contracts

There are several other RFP for stakeholder contracts that will be processed before the end of June: veterans, reducing disparities, consumers, parents of young children, and LGBTQ. The plan is to step back and learn from the contracts currently in place by engaging the contractors doing that work and others who are working in that space. The idea is to put a continuous learning process in place as these contracts come up approximately every three years. Current contracts are in place until the first quarter of next year. The intent is to have a new set of contracts in place so there will be no break in the continuity of advocacy.

One of the challenges raised in the last round was that some of the proposals only had one or two applicants. It is important to learn what worked and what did not work, particularly around local advocacy and the competitive nature of this process. These dollars need to go towards the most effective strategy. One of the goals of the listening session that will be open to the public will be to better understand how to encourage more organizations to participate.

Strategic Planning

The strategic plan is currently being drafted.

Public Comment

Stacie Hiramoto referred to the draft strategic plan that will be presented at the next meeting and stated she will resend a letter to Commissioners from a number of organizations with twelve recommendations for the Commission's operations and procedures.

Poshi Walker referred to reversion funding issue and counties being able to shift the funds rather than losing their funding if Innovation projects are not working. The speaker was part of the Technology Suite Collaborative Innovation Project commentary from the beginning and would love the ability for counties to be able to see if something did not work. The speaker stated, tying in with the idea of multiple county involvement for an Innovation project, there is supposed to be a community planning process. Innovations

and especially PEI were touted to marginalized communities as where they will fit in and where they will get funding.

Poshi Walker stated, if the community planning process is taken away and the stakeholders are not engaged as to what the community needs but rather how counties can collaborate, what might happen is exactly what happened with the Technology Suite. There were several individuals from LGBTQ communities and leaders who did not have an opportunity to speak about the Technology Suite in Orange County and were upset about how the funding was being spent, when there were no dollars going to LGBTQ services and other needs. They did not have a voice and did not know what was happening.

Poshi Walker asked Commissioners to keep that in mind as this process continues with Innovation and with multiple counties. Putting dollars towards a project that is not working and letting counties change to something that might be better is a great thing to explore.

GENERAL PUBLIC COMMENT

Stacie Hiramoto wanted Commissioners to know about the MHSA Partners Forum, a voluntary coalition of representatives of government and community members that was formed several years after the passage of the MHSA. The MHSA Partners Forum meets monthly to discuss policy issues regarding the MHSA and, in the past, have enjoyed participation by the MHSOAC. Members have asked the speaker to extend an invitation to the Chair and Vice Chair of the Commission on meeting with the group for meaningful, effective collaboration. The forum gives Commissioners and stakeholders the opportunity to dialogue about issues for better understanding rather than trying to fit input into two- or three-minute public comment periods at Commission meetings.

Poshi Walker recently attended the veteran stakeholder contractor’s statewide convening. The speaker stated there were a number of speakers who talked about MHSA funds and how they wanted MHSA funds for veterans. One of the speakers spoke about overhauling the MHSA. This is a concern. The Commission is here not only to oversee the MHSA but to oversee all public mental health services. There are disparities across the state for many populations, veterans included.

Poshi Walker stated the Commission heard today that jails would like MHSA funding and county Innovation projects would like MHSA funding. It is important to ensure that counties do not hold onto funding and not provide services to keep other individuals and organizations from coveting those dollars. The speaker stated similar comments have been heard in other places as well. It is important that the Commission be made aware of this.

ADJOURN

There being no further business, the meeting was adjourned at 3:22 p.m.

AGENDA ITEM 2

Action

September 26, 2019 Commission Meeting

DHCS Update

Summary: The Commission will be introduced to and receive an update from Dr. Kelly Pfeiffer, M.D., recently appointed as Deputy Director for Behavioral Health at the California Department of Health Care Services, on departmental priorities, activities, challenges and opportunities, including for enhanced collaboration between Counties, DHCS and the Commission in improving outcomes for Californians with mental health needs.

Presenter:

- Dr. Kelly Pfeifer, M.D., Deputy Director for Behavioral Health, California Department of Health Care Services

Enclosures (2): (1) Brief Biography for Dr. Pfeifer; (2) Staff Background Brief.

Handout: None.

Dr. Kelly Pfeifer, M.D.
Deputy Director for Behavioral Health
California Department of Health Care Services

Dr. Pfeifer was appointed by Governor Newsom in July 2019 to lead the newly reorganized Behavioral Health Division of the California Department of Health Care Services. Prior to joining the State, she had been director of high-value care at the California Health Care Foundation since 2014. She was chief medical officer of San Francisco Health Plan from 2008 to 2014, medical director at Petaluma Health Center from 2003 to 2008 and medical director for access at the Redwood Community Health Coalition from 2006 to 2008. Dr. Pfeifer practiced as a family physician at Petaluma Health Center from 2000 to 2017. She earned a Doctor of Medicine degree from Medical College of Pennsylvania and is Board Certified in family medicine, having completed family medicine training at the Sutter Santa Rosa Family Medicine Residency Program in 2000. Dr. Pfeifer is a graduate of Oberlin College, where she majored in English.

BEHAVIORAL HEALTH SERVICES AT THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES: ROLES, RESPONSIBILITIES, CHALLENGES AND OPPORTUNITIES

STAFF BRIEF

Purpose

Dr. Kelly Pfeifer, M.D., recently was appointed as Deputy Director for Behavioral Health at the California Department of Health Care Services. Dr. Pfeifer will address the Commission at its September 26, 2019 meeting. This Staff Brief provides background on DHCS and its Behavioral Health Division and identifies some opportunities for further collaboration between DHCS and the Commission toward improving behavioral health outcomes in the State.

Background

California's public behavioral health system includes services provided through five key pathways: Medi-Cal Managed Care Plans; Medi-Cal Fee-for-Service providers; County Mental Health Plan Outpatient Services; County Mental Health Plan Inpatient Services; and Drug Medi-Cal, including the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot.[1] All five pathways are overseen by the Department of Health Care Services.

Mental health programs and services predominantly are delivered in the community through county-run systems supported through Mental Health Services Act funds, State General Fund dollars federal funds (e.g., Medi-Cal Federal Financial Participation reimbursements), and direct apportionments of other taxes and fees to the counties (e.g., "Realignment" funds). In total, public funding for behavioral health in California is approximately $11 billion annually.[2]

Services covering serious mental illnesses are available through county Mental Health Plans under a federal Medicaid waiver (the Section 1915(b) Specialty Mental Health Services waiver) or through MHSA programming. "Mild-to-moderate" mental health services in the public system, since 2014, have been delivered primarily through Medi-Cal Managed Care Plans. [3]

This separation of public services for severe mental illnesses (SMI) from public mild-to-moderate services has long been recognized as a point of tension, as the dividing line between SMI and mild-to-moderate mental illness is difficult to define clearly. Each system may have financial incentives to redirect consumers in need of services to the other, which can result in consumer confusion, lack of care coordination, and, sometimes, inadequate or inappropriate care.

Additionally, most public substance use disorder (SUD) treatment services are operated through Drug Medi-Cal. The dual delivery system for mental health services, plus the separate system for SUD services, has long been recognized as a challenge to care coordination in the public behavioral health system.

Responsibility for oversight of Specialty Mental Health Services and Drug Medi-Cal falls in a Medi-Cal Behavioral Health Division reporting to the Chief Deputy Director for Health Care Programs, Mari Cantwell, under a recent Department reorganization. Oversight of other Medi-Cal mental health services, Fee for Service Medi-Cal and Managed Care Medi-Cal, including the mild-to-moderate mental health services, is the responsibility of the Health Care Systems Delivery Division, whose Deputy Director also will report to Ms. Cantwell. This reorganization has the advantage of gathering all Medi-Cal behavioral health services, including the mild-to-moderate mental health services, into one team reporting to Ms. Cantwell.

California's major federal Medicaid waivers (the Section 1915(b) waiver and the Section 1115 Medicaid Demonstration waiver covering a wide variety of Medicaid issues) are set to expire in 2020. Timely renewal and/or revision of these waivers have been identified as very high priorities by the Department.

Operational responsibility for MHSA programming is delegated to County Mental Health Plans via Performance Contracts written and overseen by the Behavioral Health Division, under Dr. Pfeifer, who will continue to report directly to the Department Director. Many MHSA programs operate by blending funds from multiple sources, including MHSA and Medi-Cal. The Departmental reorganization thus creates new opportunities for examining how well County Mental Health Plans are able to leverage their MHSA funds to draw down federal Medi-Cal match dollars and meet local needs.

Critically, the Act also specifies that sufficient State administrative funds be allocated each year to "ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth" in the governing language for the Adult and Older Adult System of Care, Children's System of Care, and Prevention and Early Intervention programming.[4] DHCS is required to perform comprehensive reviews of County MHSA programs at least once every three years.

The MHSA specifically states that MHSA funding for services for adults and older adults with serious mental illnesses "shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds."[5] A parallel requirement applies to services for children.[6] More generally, the Act states that "The funding established pursuant to this act shall be utilized to expand mental health services. ...these funds shall not be used to supplant existing state or county funds utilized to provide mental health services."[7]

These various provisions create ongoing obligations to demonstrate that MHSA funds are being used as resources of last resort and to leverage other funding sources, that the total delivery of services is increased over what could have been delivered in the absence of MHSA funding, and that Counties are evaluating their programs and implementing effective strategies to improve client outcomes.

Finally, the Governor's 2019-20 budget identified three emerging challenges to the public mental health system to include[8]

- the state's growing homeless population (which has a high prevalence of mental illness and substance use disorders, often as co-occurring conditions that can significantly complicate treatment of each);
- a growing need for mental health practitioners; and
- the need to continue to seek new, innovative approaches to intervene as early as possible when mental illness is detected, especially in young people.

These various priorities and the DHCS reorganization raise new opportunities for the Commission and the Department regarding how the State can best support County Mental Health Plans to meet local behavioral health needs.

Considerations

Commissioners may wish to consider the following questions as they engage with Dr. Pfeifer:

- What is Dr. Pfeifer's vision for the Division over the next three to five years? What does she see as the most important opportunities for the Commission and the Division to work together to improve transparency, accountability, and outcomes for Californians with behavioral health needs?

- How does she foresee collaborating with the DHCS divisions responsible for Medi-Cal-funded behavioral health services and fiscal oversight, respectively, and what are the key opportunities facing the Department in improving the coordination of care for individuals in need of behavioral health services in the public system?
- The Division recently began conducting triennial MHSA program reviews of county MHPs. What are the key performance questions that Dr. Pfeifer expects to focus on relating to those reviews in the near and medium terms, and why?

- Recent legislation has reemphasized the importance of timely, transparent fiscal reporting of MHSA revenues, expenditures and unspent funds. What can the Department and the Commission do to better ensure that the public has timely access to MHSA fiscal information sufficient to support robust public participation in local community program planning?

- The Act specifically requires implementation of a "comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system." What is her vision for outcomes evaluation and reporting, and how can the Commission best assist in its implementation?

- The Act requires both the Counties and the Department to maintain an "Issue Resolution Process" for addressing complaints arising under the MHSA. Little information is available about these IRPs or their integration with alternative complaint processes, such as the required Dispute Resolution Process under Medi-Cal. What is Dr. Pfeifer's vision for coordinating MHSA Issue Resolution Processes with existing Medi-Cal related dispute resolution processes at the State and local levels?

- What is Dr. Pfeifer's view of county needs for technical assistance in achieving excellence in behavioral health? What opportunities does she see for collaboration between the Commission and the Department to support continuous quality improvement in behavioral health across the State?

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[1] See Tatar, Margaret, and Richard Chambers. 2019. "Med-Cal and Behavioral Health Services." Medi-Cal Explained Fact Sheet. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2019/02/MediCalExplainedBehavioralHealth.pdf (accessed September 5, 2019)
[2] See Blue Sky Consulting Group. 2019. "Public Financing of Behavioral Health Services in California." Sacramento: Blue Sky Consulting Group. See also California Department of Health Care Services, May 2019. "Mental Health Services Act Expenditure Report—Governor's May Revise, Fiscal Year 2019-20." https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA-ExpendRpt-May2019.pdf (accessed September 10, 2019).
[3] For more information on Medi-Cal Managed Care Plans, see the Department of Health Care Services' fact sheet, "Medi-Cal Managed Care Program Fact Sheet: Managed Care Models." , https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf. (Accessed September 5, 2019)
[4] Welfare and Institutions Code Section 5892(d).
[5] Welfare and Institutions Code Section 5813.5(b).
[6] WIC Section 5878.3(a).
[7] Welfare and Institutions Code Section 5891(a).
[8] 2019-20 Governor's Budget, Proposed Budget Summary, Health and Human Services, p. 65. http://www.ebudget.ca.gov/2019-20/pdf/BudgetSummary/HealthandHumanServices.pdf (accessed September 5, 2019)

AGENDA ITEM 3

Action

September 26, 2019 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of the following County Innovation Plans placed on the Consent Calendar:

(A) **<u>Sutter-Yuba County</u>: Authorize the County to expend up to $5,228,688 in MHSA Innovation funds over five years in support of the Innovative & Consistent Application of Resources and Engagement (iCARE) Project.**

Sutter-Yuba County Behavioral Health (SYBH) requests authorization to expend Innovation funds to create a mobile team to engage with individuals prior to and after hospitalization. This innovation project proposes to focus on increasing consumer engagement for individuals who recurrently access emergency room and crisis services when experiencing severe and chronic behavioral health symptoms. The County intends to leverage MHSA Prevention and Early Intervention funds in this project to provide community-wide training focusing on mental health to educate their community and reduce stigma.

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.

Enclosures (3): (1) Innovative & Consistent Application of Resources and Engagement Staff Analysis; (2) Innovative & Consistent Application of Resources and Engagement Final Plan; (3) Letters of Support for Sutter-Yuba Innovation Plan.

Proposed Motion: The Commission approves all items on the Consent Calendar as presented.

STAFF ANALYSIS – SUTTER-YUBA

Innovation (INN) Project Name:	**Innovative & Consistent Application of Resources and Engagement (iCARE)**
Total INN Funding Requested:	**$5,228,688**
Duration of INN Project:	**Five (5) years**
MHSOAC consideration of INN Project:	**August 22, 2019 Via Consent Agenda**

Review History:

Approved by the County Board of Supervisors: August 13, 2019
Mental Health Board Hearing: June 13, 2019
Public Comment Period: May 6-June 5, 2019
County submitted INN Project: June 17, 2019
Date Project Shared with Stakeholders: May 17, 2019 and July 26, 2019

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D):

Primary Purpose of INN 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, supports or outcomes
☐	Increases access to mental health services, including but not limited to services provided through permanent supportive housing
This Proposed Project meets one of the following criteria:	
☐	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 on site

Project Introduction:

Sutter-Yuba County Behavioral Health (SYBH) is requesting authorization to use up to $5,228,688 of Innovation spending authority to create a mobile team to engage with individuals prior to and after hospitalization. This innovation project proposes to focus on increasing consumer engagement for individuals who recurrently access emergency room and crisis services when experiencing severe and chronic behavioral health symptoms. Additionally, with the use of MHSA Prevention and Early Intervention funds the County will leverage this project to provide community-wide training focusing on mental health in an effort to educate their community and reduce stigma.

What is the Challenge or Problem?

The County states there is an under-utilization of outpatient behavioral health services sought and/or received within the first 30 days of being discharged from a psychiatric inpatient setting or receiving psychiatric emergency services. The County has previously collaborated with Adventist Rideout Regional Hospital to embed County crisis counselors in the emergency room while telehealth was provided by Rideout clinicians. Despite the collaboration, the County contends the use of outpatient services has remain unchanged. The County states lack of engagement in outpatient services may be attributable to various reasons to include consumers not being ready to participate in the behavioral health system while other consumers who may not believe they have a mental illness so they may be disengaged from the behavioral health system altogether.

Data provided by the County for the 2018 calendar year indicates the following:

- SYBH provided crisis and emergency psychiatric services to 2,702 individuals
- Of those 2,702 individuals, **1,995** were 5150 involuntary holds
    - 500 of those 2,702 individuals received inpatient psychiatric care
    - 49% (n=997) of 5150 holds were written by law enforcement
    - Remaining 5150 holds (n=998) were written SYBH crisis staff
        - 404 of those 998 were written at the hospital for those individuals who were transported there via law enforcement
    - The sum of involuntary holds either placed at the hospital or by law enforcement totals 70% (n=1,401) of the 1,995 individuals placed on an 5150 involuntary hold

Of the 500 individuals who received inpatient psychiatric care, less than 2% (n=25) followed up with treatment within the following 30 days of being discharged. Only a select few of those 25 individuals were enrolled into Full-Service Partnership services, despite some of those individuals spending more than 200 days in an inpatient hospital within a one-year period.

This data validates that consumers are not following up or are not able to adequately access and receive outpatient care. These findings prompted the County to ask their consumers why outpatient services weren't being utilized. The County reported that their consumers have voiced there is a negative attitude and perception surrounding mental health in the community which delays consumers from seeking treatment. Even health

care practitioners in the County question the efficacy of behavioral health and are skeptical of psychiatric care.

In order to increase the utilization of SYBH Outpatient Services, reduce the County's reliance on emergency room services and law enforcement, and decrease the negative attitude and stigma around mental health, the County proposes to develop the Innovative & Consistent Application of Resources and Engagement (iCARE) Mobile Crisis Team.

What is the Innovation?

To increase engagement after receiving emergency or psychiatric inpatient care, the County is proposing to mobilize iCARE (Innovative & Consistent Application of Resources and Engagement) teams. The teams will consist of peers with lived experience, alcohol and drug counselors, and nursing and behavioral health clinicians. The team will offer an engagement approach by utilizing the COACH model, designed to build trusting, empowering relationships with patients to guide them towards sustained behavior change. The iCARE team hopes to utilize the COACH (**C**onnect tasks with vision and priorities; **O**bserve the normal routine; **A**ssume a coaching style; **C**reate backwards plan; **H**ighlight progress with data) model to problem-solve with consumers to assist in determining how to effectively engage with and manage their health conditions and reduce future hospital admissions. Additionally, iCARE teams will utilize the LEAP (**L**isten, **E**mpathize, **A**gree, **P**artner) model which is useful for transforming and building trust in relationships which may ultimately result in encouraging someone with a serious mental illness to accept treatment. The County does not currently have a mobile crisis team in place and this innovation project would allow the County to test the effectiveness in increasing post-discharge engagement by utilizing the COACH and LEAP models.

iCARE teams will meet consumers where they are and the focus will be to build trusting relationships with consumers and their families in a non-clinical setting until the individuals feel they are ready and capable to engage in and navigate through the behavioral health system with the assistance of one of the team members. If there is a concern for their safety, law enforcement may also be deployed to accompany the iCARE teams.

Family members of consumers may also seek to refer their loved ones to the iCARE teams and may receive education and training regarding types of services that are available, coping skills, and learning about their loved one's behavioral health conditions.

Another element of this innovation project revolves around community training. The County has expressed there is stigma and negative perceptions surrounding mental health which includes physical health practitioners. Research for this project led the County to communicate with San Bernardino who is also utilizing the LEAP model to engage with homeless individuals in one of their current innovation projects. Sutter-Yuba inquired into lessons learned and the successes and challenges of their current program. San Bernardino shared that if they had to do the project over again, they would train their behavioral health department to utilize the LEAP model.

As a result of this insight, Sutter-Yuba will begin a community level education strategy beginning with the Sutter-Yuba health workforce (approximately 225 employees) and at

least 100 heath care providers located in the local emergency rooms in the utilization of the LEAP model to bring awareness and sensitivity when engaging with consumers. Additionally, the County wants to increase community awareness and outreach by offering voluntary trainings to community organizations and partnerships in the areas of mental health first aid, community LEAP, and trauma informed care trainings. The County hopes these community trainings will aid in the reduction of negative feelings, perceptions, and stereotypes related to mental health illnesses.

With this innovation project, the County hopes to learn if the use of the LEAP and COACH models will be effective in increasing engagement in individuals who recurrently seek crisis care services. Although the LEAP model is being utilized in San Bernardino, Sutter-Yuba would like to learn if this model is effective in their community where resources are scarce, and stigma is prevalent.

The use of the LEAP and COACH models employed by the iCARE teams, combined with community-wide education and training will alert the County as to whether engagement is increased and if there is a reduction of crisis services utilized as a result.

This innovation project's strength is that it is a multi-faceted proposal that not only hopes to increase the utilization of Sutter Yuba County's outpatient behavioral health services, but also aims to change the culture in the community around mental health.

Learning Objectives and Evaluation:

Sutter-Yuba seeks to better understand the extent to which the implementation of mobile teams trained in LEAP and COACH can result in increased access to care and improved engagement for the target population. Additionally, Sutter-Yuba seeks to evaluate the effect that these engagement models can affect law enforcement calls for services and 5150s. The project will meet the primary purpose of increasing access to mental health services to underserved groups. The County will target individuals who traditionally do not engage in services upon discharge from hospitalization or crisis care. It is the hope of the County to serve 50-individuals per year or 150-individuals over the course of the 5-year project.

To guide their project, Sutter-Yuba has posed several learning questions that will meet the challenge and problem they have sought to resolve by examining the extent to which the LEAP and COACH models improve engagement and other outcomes (**see pgs. 23-25**). Additionally, the learning questions establish a mechanism that will meet the primary purpose of the project. This will be accomplished by establishing a baseline of information consisting of (but not limited to) outpatient services utilization, consumer engagement, and number of hospitalizations. The outcomes, measurement metrics, data sources identified by the County are all appropriate for a full evaluation of the learning objectives of the project (**see pgs. 23-25**).

An outside contractor who will also complete the final evaluation plan will conduct the overall evaluation. At the conclusion of the project, the Counties will share lessons learned and findings through presentations given to community groups, service providers,

law enforcement, and other local entities. Additionally, SYBH will promote community trainings and work with local community groups to facilitate trainings.

Additional Regulatory Requirements:

The Community Program Planning Process

Sutter-Yuba County held their 30-day public comment period beginning on May 6, 2019 through June 5, 2019. The County's local Mental Health Board held their public hearing on June 13, 2019 and is anticipating receiving subsequent Board of Supervisor approval on August 13, 2019.

The County held a total of four public planning sessions in both counties and an additional 10 targeted stakeholder forums for a total of 14 meetings. These meetings included, but were not limited to consumers, family members, county staff, social services, law enforcement, community-based organizations, mental health professionals and schools. Comment cards were collected at all stakeholder meetings and the County included all the comments received as part of this project (*see Appendix*). There were suggestions made from stakeholders seeking clarification of how referrals could be made as well as the request for the community to receive trainings along with family outreach support. The County states they have incorporated these suggestions in the final version of this project plan.

The County states stakeholders, including consumers and family members, have been and will continue to be actively involved in all phases of the innovation project. If approved, the County states they will create an innovation operations committee represented by family members, consumers, and stakeholders who represent the cultural diversity of the County to continue stakeholder involvement in the implementation, evaluation, and operation of this project.

Commission staff initially shared this Innovation Project with stakeholders on May 17, 2019 while the County was in their public comment period and the final version of the plan was again shared on July 26, 2019. The first time the project was shared with stakeholders, no letters of opposition or support were received by Commission staff. The sharing of the project in July 2019 yielded two letters of support. One consumer indicated their loved one would definitely benefit from a program like this until they reached the point where they were ready to engage with outpatient treatment. The other letter of support was from United Parents, stating this County "relied heavily on consumer and family member input" and the community education element will offer stigma reduction based upon consumer and family member feedback.

As part of MHSA General Standards, Sutter-Yuba County states this innovation project will depend heavily upon community input and the coordination of services among various community-based organizations. Further, the County states they will ensure cultural competence in this project as well as within their community. This project is client-driven and is focused on the needs of the consumers with the support of family members with emphasis based on recovery, wellness, and resilience.

<u>The Budget</u>

Sutter-Yuba's total project plan is $5,939,288; however, the County is seeking approval of MHSA Innovation funds up to the amount of $5,228,688; over five (5) years.

Direct costs in the amount of $3,979,838 represent 67% of the total budget and cover expenses such as care costs for consumer outreach and engagement, fuel for the vehicles purchased as well as supplies. Indirect costs in the amount of $1,637,600 and represent 28% of the total budget. These costs will cover the costs of the community-based trainings along with rent and utilities. Non-recurring costs and other expenditures (purchase of five mobile care vans, laptops, cell phones, wireless printers, and iCARE uniforms to identify team members) are estimated to cost $321,850 and represent 5.4% of the total project budget.

In terms of sustainability, the County states they may continue this project in whole, or in part, utilizing both Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) funding. The County may additionally sustain this project with the use of grant funding or may seek medi-cal reimbursement for eligible services rendered.

Pursuant to Assembly Bill 114, Sutter-Yuba will initially utilize a total of $2,828,688 in funds subject to reversion from previous fiscal years (FY 08/09, FY 09/10, FY 11/12, FY 12/13, FY 13/14, and FY 14/15). Additionally, the County is leveraging this project by utilizing Prevention and Early Intervention funding in the amount of $710,600 which will be used towards the LEAP, COACH, and community-based trainings.

Review of CCR Section 3930 requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

Comments:

The mobility of these field-based teams will allow greater engagement with consumers post-discharge or after crisis services have been received. Building trust with consumers will be pivotal in encouraging engagement and the peer with lived experience is a critical component of this team.

The County embarked on a robust community planning process and the community seems to be in strong support of this project.

References:

Camden Coalition of Healthcare Providers (2016). The Coach Manual. Retrieved from: https://www.camdenhealth.org/wp-content/uploads/2017/04/COACHManual_FINAL_WithAppendix_Dec2016.pdf

https://leapinstitute.org/

http://mhr4c.com.au/coping-strategies/the-leap-approach/

Innovative & Consistent Application of Resources and Engagement (iCARE) Innovation Plan

GENERAL REQUIREMENT:

☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population. This proposed project is based on the experience of the San Bernardino County Department of Behavioral Health's Innovation Plan approved in 2015 as well as the experience of other health care systems in implementing transformative practices increasing consumer engagement in healthcare, specifically hospitals and providers in Camden, New Jersey.

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.

Sutter-Yuba Behavioral Health's primary purpose for implementation of the iCARE Innovation project is: *to increase access to behavioral health care for underserved groups experiencing difficulty engaging in outpatient behavioral health and substance use disorder treatment services.* Secondary results will also be demonstrated through the project as evidenced by: increased quality of mental health services, including measurement of outcomes, promotion of interagency and community collaboration related to Mental Health Services, supports or improved individual and community level outcomes.

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 purpose for creation of the Innovative & Consistent Application of Resources and Engagement (iCARE) Team in Sutter County and Yuba Counties is to better address the needs of the community on three levels:

1) At the individual level for consumers through increased engagement with available behavioral health services.
2) At the behavioral health system level through transformation of professional provider engagement practices.

At the community level through transformation of community views on behavioral health conditions and accessing behavioral health care.

Specifically, iCARE is intended to increase consumer engagement in outpatient behavioral health care for individuals experiencing severe and chronic behavioral health conditions who primarily access emergency, crisis and inpatient services. iCARE also seeks to dispel misconceptions, myths, address stigmas related to behavioral health care and increase engagement support for those accessing behavioral health services. iCARE is designed to increase levels of comfort individually and in the community related to accessing behavioral health care in a rural, small, bi-county setting, while fostering collaborative cross-sector working relationships, positive behavioral health experiences and wellbeing for consumers served by Sutter-Yuba Behavioral Health.

On November 13th, 1972 Sutter-Yuba Behavioral Health (SYBH), then- Bi-County Mental Health Department established a JPA approving a Bi-County Mental Health Program for the counties of Sutter and Yuba. Since 1972, SYBH has continued to provide services to individuals and families who are experiencing serious or ongoing mental health and/or substance use disorders in Sutter and Yuba counties. These services have traditionally been provided in the conventional or clinical manner, i.e., in-office visits, office-based groups, occasional home visits, and embedded models within programs such as children and family services and probation, but with limited community engagement on the benefits of behavioral health services.

Per the 2010 Census, the total population for Sutter and Yuba Counties combined is 167,888. According to 2014 population estimates, Sutter County is home to approximately 95,733 people. There are two incorporated cities, Yuba City with a population of 65,677 (2014), and Live Oak with 8,481 (2014) residents. The remaining residents live within the small communities of Tierra Buena, Meridian, Rio Oso, Trowbridge, Sutter, Pleasant Grove, Nicolaus, East Nicolaus, Riego or Robbins, or reside in the vast rural, agricultural areas which make up Sutter County.

The 2010 U. S. Census shows that Caucasians made up nearly 65.5% of Sutter County's population. The remainder of the population includes Hispanic or Latino (28.8%), Asian/Pacific Islander, including Sutter County's large East Indian population (11.1%), African Americans (1.8%), and Native Americans (1.4%).
The median age in Sutter County, according to the 2010 census, was 34.5 years, and children accounted for over 32.7% of the population while seniors (65 and older) made up approximately 12.7%.

In the 2015 Report of Registration, there were 41,508 registered voters in Sutter County with party affiliations of Republican (43%), Democrat (31%), declined to state (no party) (18%), American Independent (3%), other (2%), Peace and Freedom (.33%), Libertarian (.68%), and Green (.31%).

In a California Employment Development Department February 2019 Monthly Labor Force Data for Counties study, the unemployment rate in Sutter County was 9.7% (4,500 individuals unemployed). Sutter County is currently number 50 of 58 counties, where 1 is the lowest county unemployment rate and 58 is the county with the highest unemployment

rate. Many people who choose to live in Sutter County commute to work in one of the many surrounding counties.

The availability of water, plus long sunny growing seasons, make Sutter County a fertile area for agriculture. With over 77% of the County's total acreage classified as "important farmland," with 43.5% considered prime, coupled with the high value of agricultural production, Sutter County is one of the most intensively farmed counties in California. Agricultural products grown in Sutter County are exported throughout the world.

Yuba County is one of California's original 27 counties founded on February 18th, 1850. Agriculture plays a major role in Yuba County's economy, especially fruit orchards, rice fields, and cattle grazing. Other major employers include Government and Healthcare. The 2010 United States Census reported that Yuba County had a population of 72,155. The demographics of Yuba County, at the time of the Census, was 49,332 (68.4%) White, 2,361 (3.3%) African American, 1,675 (2.3%) Native American, 4,862 (6.7%) Asian, 293 (0.4%) Pacific Islander, 8,545 (11.8%) from other races, and 5,087 (7.1%) from two or more races. Hispanic or Latino of any race were 18,051 persons (25.0%).

The median age in Yuba County, according to the 2010 census, was 32.2 years, with children accounting for 32% of the population and seniors (65 and older) making up approximately 10.1%.

In the 2015 Report of Registration, of the 47,937 eligible voters, there were 27,318 (57%) registered voters in Yuba County. Party affiliations included, Republican (39%), Democrat (30%), declined to state (no party) (24%), American Independent (5%), other (.25%), Peace and Freedom (.37%), Libertarian (.96%), and Green (.51%).

In a California Employment Development Department February 2019 Monthly Labor Force Data for Counties study, the unemployment rate in Yuba County was 7.8% (2,300 individuals unemployed). Yuba County is currently number 42 of 58 counties, where 1 is the lowest county unemployment rate and 58 is the county with the highest unemployment rate.

Established in 1842, Marysville, is located on the west county-line. The only other incorporated city, in Yuba County, Wheatland, is located on the southeastern county-line. In the 2010 Census, 12,072 people resided in Marysville and 3,456 people resided in Wheatland, with the remaining 56,879 residents (79%) of Yuba County living in an unincorporated area. Residents also live within the small communities of Linda, Olivehurst, Arboga, and Plumas Lake. Additionally, Beale Air Force Base, a local military base in Yuba County was established in 1942, then- referred to as Camp Beale, and housed POWs during WW II. Today the Air Force Base covers nearly 23,000 acres. The remaining Yuba County townships in the Sierra Nevada foothills are the communities of Iowa City, Smartsville, Browns Valley, Loma Rica, Camptonville, Dobbins, Rackerby, Challenge-Brownsville, Oregon House and Strawberry Valley which is located 43 miles from Marysville.

Yuba County has one major river, the Yuba River, which is comprised of three forks that begin in the Sierra Nevada Mountains and feed the larger watershed. The availability of water, plus long sunny growing seasons, make Yuba County a fertile area for agriculture. In 1997, Yuba County was ranked 6th among the nation's counties in production of peaches and sixth in production of plums and prunes. A 2010 Yuba County Crop Report states, "the top six agricultural commodities in Yuba County were, rice, walnuts, plums/prunes, peaches, milk and cattle, in that order."

Sutter and Yuba County residents value the local geography, proximity to two rivers, rich agricultural soil and foster a sense of community appreciation for a slower pace that increases quality of life, including affordability. While social media use is less typical for all ages, youth and young adults primarily access information via social media, while adults, older adults and elderly value more traditional media to include printed or web-based newspapers, mailed letters, or gaining information at community gathering places such as senior/community centers and churches.

Sutter and Yuba counties are served by one large hospital, Adventist Health+ Rideout Hospital, two Medi-Cal Managed Care Plans (Anthem Blue Cross and California Health and Wellness), commercial insurances and several large and small healthcare practices. Network availability for healthcare providers, to include primary care and specialty providers has been historically low, with Sutter and Yuba counties struggling to attract healthcare providers to the region with the hospital serving as a main source of healthcare access.

In a 2016 Community Health Needs Assessment, Adventist Health+ Rideout Hospital and Sutter Surgical Hospital – North Valley Service Area, identified access to transportation and mobility as the sixth highest priority for significant health need in the Bi-County region, to include populated city areas. Residents living in both city and rural areas experience economic disparities which contribute to difficulty in accessing services as vehicles are unavailable to some of them.

In some instances, residents live in rural mountain towns on dirt roads. To make a drive into "town" takes more than an hour over 40 plus miles of winding mountain roads, which are often affected by inclement weather and flooding during winter months. In these rural areas public transit is not accessible, there are no street lights and the remote nature of the location is an attraction for residents.

Residents who live in various rural areas of both counties often appreciate the ability to live independently, with little reliance on others. This includes efforts to avoid being a "burden" to taxpayers and limited interaction with government or public health care providers. Due to the goldrush history of the region, as well as the proximity of Beale Air Force Base, residents often identify with "pulling themselves up by their boot straps" when it comes to behavioral health care conditions.

According to the 5-year strategic plan to respond to homelessness in Sutter and Yuba Counties published in January 2019, Sutter and Yuba Counties have experienced a

particularly striking increase in homelessness over the past decade. Specifically, the reported number of persons experiencing homelessness has more than doubled from 362 in 2007 to 760 in 2017. During the same time period, the number individuals experiencing chronic homelessness has more than tripled – from 44 persons in 2007 to 150 persons in 2017. The severity of this increase in the prevalence of homelessness is exacerbated by the fact that the majority (62.2%) of persons experiencing homelessness are unsheltered.

This is true for several populations of focus among persons experiencing homelessness as well, including individuals with severe mental illness (51.9% unsheltered), Veterans (57.4% unsheltered), unaccompanied youth (62.5% unsheltered), parenting youth (66.6% unsheltered), and children of parenting youth (70% unsheltered). It is important to note that the reported numbers of persons experiencing homelessness for 2017 are likely underestimated. For example, the number of self-declared persons experiencing homelessness reporting to the Yuba County Department of Health and Human Services Department far exceeds that count. It is estimated, in actuality, the Bi-County region has a total homeless population ranging from 800 to 1,000 individuals (*5-year strategic plan to respond to homelessness in Sutter and Yuba Counties, January 2019).*

As the Mental Health Plan for Sutter and Yuba counties, SYBH is responsible for providing specialty mental health services (SMHS) to include community-based mental health and substance use disorder treatment programs for those who have Medicare, Medi-Cal, are uninsured, have low income and are underserved, unserved or inappropriately served.
In FY 17-18, SYBH served 5,408 unique individuals, approximately 3.22% of the total population of 167,888 residents. Per the National Institute of Mental Health (NIMH), prevalence rates for individuals estimated to live with severe and persistent behavioral health conditions is 4%, or for our region, 6,715 individuals. Thus, it is likely that SYBH is underserving our target population.

Of the 5,408 persons seen, 53% identified as female, 47% as male, and less than one percent as other. Additionally, 65% identified as White, 14% Latino, 4% African American, 4% Asian/Pacific Islander, 1.5% Native American, with an additional 6% identifying as two or more ethnicities, 4% not reporting and less than one percent as other.

Services for those with chronic and persistent behavioral health conditions have historically been provided in conventional service delivery structures focusing on inpatient care, outpatient programs requiring consumers to “come to” the public behavioral health clinics, and traditional case management for both behavioral health and substance use disorders treatment.

A previous behavioral health crisis services innovation effort that began in FY 15/16 has resulted in a unique collaboration between SYBH and Adventist+ Rideout Regional Hospital. In this model, SYBH embeds crisis counselors and licensed staff, while Adventist+ Rideout provides telehealth in the local emergency room. Despite this collaborative effort, the rest of SYBH’s Behavioral Health Outpatient Service Delivery System remains largely unchanged. Service provision is dependent upon the consumer’s

ability to come to office visits or attend structured appointments. While Full Service Partnership (FSP) programs exist, they are underutilized.

SYBH works collaboratively with nine law enforcement entities between Sutter County and Yuba County to include county probations, sheriff's departments, city police and the California Highway Patrol. Interagency and department relationships with law enforcement partners are highly collaborative and strong. However, SYBH law enforcement partners continue to receive a high number of behavioral health related calls, including 5150 evaluations.

During calendar year 2018, SYBH provided crisis/emergency psychiatric services to 2,702 individuals. Of those seen, 1,995 were seen via 5150 or involuntary holds. In 2018, law enforcement wrote 997 (49%), of the total 1,995 holds placed in both counties for children and adults. The remaining 998 holds were written by SYBH crisis staff, with 404 of 998 being written at the hospital for individuals transported to the hospital via law enforcement. Thus, adding holds placed at the hospital with holds written by law enforcement, is 70% (1,401) of the total 1,995 holds, a significant percentage of total crisis contacts.

Of those 2,702 who were provided crisis services, over 500 received inpatient hospital care. Of those 500 who had both mental health and substance use disorders (co-occurring conditions), less than 2% followed up with outpatient behavioral health and substance use disorder treatment within 30 days of receiving psychiatric emergency services or discharge from a psychiatric inpatient setting. Of the 25 individuals receiving the most hospital care, some with more than 200 days of acute inpatient hospital care in one year, only 8% were enrolled in FSP services.

Based on this data it is clear to SYBH that a large percentage of individuals seeking emergency, crisis and hospital care are not successfully connecting with outpatient care and are caught in an emergency services pattern.

When SYBH has asked consumers why they aren't connecting with outpatient care after seeking emergency or crisis care, they have reported:

"Services at SYBH don't/won't help me."

"The wait is too long."

"There is too much paperwork."

A large percentage of consumers accessing emergency and crisis services are new to the public behavioral health system, presumably because SYBH has been fully imbedded in the local emergency room 24/7 since FY 15/16. Additionally, there is a sense among consumers that they suffer from discrimination due to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, even with some SYBH staff.

Consumers report being aware of negative feelings, attitudes, beliefs, perceptions, and stereotypes in the local community that make them hesitant of "being seen" at the behavioral health sites in the local community. Behavioral health stigma is considerably high and public education regarding behavioral health care, benefits of services, and positive impacts of recovery and wellness have not been widely discussed. This is due to the rural nature of both counties and a slower pace for behavioral health system transformation. Thus, community behavioral health education aimed at addressing stigma associated with behavioral health care has been slower to develop within the community at large. This includes the general healthcare community, with some practitioners questioning the effectiveness of behavioral health care services and remaining generally distrustful of psychiatric care.

Also, a percentage of consumers do not believe they have mental illness and this belief informs their lack of interest in coming to outpatient care despite accessing significant amounts of emergency and crisis services.

Thus, SYBH is proposing the iCARE team, a mobile, field capable, non-clinical, relational based engagement team meeting consumers where they are in a "go to" model. The iCARE Team will also offer therapy and psychosocial education to family members/support persons of individuals with chronic mental health conditions and substance use disorders to strengthen coping skills, knowledge of behavioral health care conditions and treatments. Lastly, the iCARE Team will partner its approach with a large scale, concurrent public education effort widely offering community and employer-based training related to behavioral health care conditions, wellness, recovery, and stigma reduction.

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.*

SYBH's outpatient service delivery system is currently built to serve individuals able to engage in available outpatient treatment. Thus, based on consumer and provider feedback, data review of service patterns, and community feedback, SYBH is proposing to implement the iCARE Team, which will include Peer staff with lived experience working alongside clinicians in Sutter and Yuba counties. The iCARE Team is based on successful engagement practices tested in San Bernardino County's Department of Behavioral Health, Recovery Based Engagement Support Teams (RBEST) innovation project, and Camden Coalition of Healthcare Provider's COACH model, engaging and empowering patients. The iCARE Team would focus on safely working with individuals not ready or able to engage with available outpatient treatment while concurrently working to strengthen individual and community support systems.

Specifically, SYBH is proposing the iCARE Team respond to individuals in a non-clinical, mobile, field-based approach prior to and after hospitalization, in consumer homes, homeless encampments, emergency rooms, with law enforcement or other community settings who:

- Utilize crisis, emergency, and inpatient hospital care as their main source of behavioral health treatment
- Have high contact with law enforcement
- Are unengaged in available outpatient behavioral health and substance use disorder treatment, or engaging ineffectively in available outpatient care
- Are vulnerable due to difficulty making transitions between hospital and outpatient care
- Experience difficulty accessing behavioral health care for the consumer and or family member/caregiver
- Have inadequate support from family or support systems
- Have numerous negative past experiences with behavioral health care
- Experience discrimination and or isolation due to behavioral health illness
- Have difficulty traveling to and dealing with wait times for appointments
- Are unable to complete multi-step processes and multiple assessments without support
- Have difficulty utilizing follow-up instructions in managing their own health care needs, independently managing their care or identifying their needs

The iCARE Team is not a case management approach, but rather an engagement approach. The iCARE Team will engage with consumers using open ended questions to understand what the consumer truly wants for themselves, observe the consumer without judgement and seek to understand how the consumer manages his/her behavioral health care condition to better partner with them. Additionally, the iCARE Team will aim to transform engagement practices of clinical and administrative staff throughout the entire department.

The iCARE Team will consist of culturally competent peer advocates in paid positions with lived experience, alcohol and drug counselors, nursing and behavioral health clinicians that will respond to consumers where they are.

Consumer engagement will be based on the Listen Empathize Agree Partner (LEAP) model developed by Dr. Xavior Amador and the COACH model developed by the Camden Coalition of Healthcare Providers in Camden, New Jersey. The LEAP model is specific to those with chronic behavioral health conditions and focuses on transforming relationships with consumers first. The COACH model is specific to health care practices and techniques employed by care teams to establish an authentic healing relationship resulting in measurable change in the consumer's health status. In addition to the iCARE Team, SYBH's entire behavioral health workforce will be trained in the LEAP model, including administrative staff to ensure all programs are utilizing LEAP engagement strategies from reception to clinical and medical services. Clinical staff will also be trained

in the COACH model. Both models, COACH and LEAP contain elements of the recovery model established by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The iCARE Team approach will be non-traditional. The goal is that the highest utilizers of psychiatric emergency services, (those having contacts with law enforcement and the emergency room), will be engaged by a team that doesn't focus on the traditional clinical aspect of treatment. Rather, the team changes their approach to meet the needs of the individual in settings outside of the clinic. The team will focus on peer support, psycho-education and assistance that does not require a person to "jump through hoops" to begin the treatment engagement process. Simply stated, the focus will be to build trust, consistency with professionals, and improvement in the life of the individual until they are at a point that they are able to engage in clinical treatment. Once the person feels comfortable and ready to engage, the identified team member will help the individual navigate the clinical treatment process at their pace and without the stringent requirements placed on traditional methods of engagement.

Because a high percentage of individuals needing behavioral health services are presenting to law enforcement and emergency room staff as their chosen source of care, the iCARE Team will deploy with members from community partners having good rapport with consumers, including law enforcement, emergency department case managers, or other supports as appropriate. The iCARE Team may also deploy with law enforcement if there is a concern of safety for the mobile engagement team or the consumer. Additionally, ER case managers who also participate in the street medicine team, which is a hospital based mobile medical team, may also deploy with the iCARE team to better meet consumer medical needs in the spirit of whole person care, and as appropriate.

If available and interested, the iCARE team will also work with family members of those consumers they are seeking to engage to offer coping skills, education about chronic behavioral health conditions, types of services available, and how to access them. Family members may also make referrals to the iCARE Team at any time. Once established, the iCARE Team will conduct community presentations to family member specific groups, and individually to family members in the community or loved ones seeking services with SYBH on how to refer to the iCARE team. The iCARE Team will also present to support groups at the local hospital and other community settings to ensure that we reach family members. The referral process will include a referral form that will identify how to make a referral and will contain the following information:

1) **What does the iCARE Team do**?
    - The iCARE Team provides community (field-based) services in the form of outreach, engagement, care management, family education, support, and therapy for the most challenging diverse adult clients in the community who suffer from untreated mental illness in an effort to "activate" the individual into the mental health system to receive appropriate services.
    - The iCARE Team is **not** a resource connection or case management program for someone who is compliant with their treatment. However, if a

referral is received, the screening process will identify appropriate resources and the referral may be re-routed to the appropriate program.

2) **When did the iCARE Team begin providing services**?
   The iCARE Team is funded by the Innovation component of the Mental Health Services Act (MHSA), which is a time limited project, with services beginning in March, 2020.

3) **In order to be served by the iCARE Team, the adult (age 18 and over) must meet at least one (1) of the following criteria:**
   - Does not follow through or refuses necessary outpatient treatment.
   - Often uses crisis services (police, psychiatric hospitals and emergency departments) without outpatient treatment follow-up.
   - Has been cared for in private residences by families and loved ones without the assistance of needed effective behavioral health supports.

4) **How does someone make a referral**?
   A referral form for the iCARE Team has been created and can be completed by anyone by doing one of the following:
   - Call an iCARE staff member at TBD
   - Email the completed the referral form to TBD
   - Fax the completed referral form to TBD **Attn: iCARE Team**
   - Mail the completed referral form to: TBD

The iCARE Team will also be implemented concurrently with a large community education strategy focused at community level education and stigma reduction funded by prevention and early intervention funds. Over the last year, SYBH has recognized the need to develop a more robust, upstream approach to behavioral health needs by increasing efforts that engage, encourage, educate and facilitate learning for recognizing and responding effectively to early signs mental illness.

Thus, SYBH is proposing to significantly increase community education by several thousand available hours utilizing universal and selective prevention activities in much greater numbers than in the past. Universal prevention activities are aimed at the general public or whole population groups that have not been identified on the basis of individual risk and includes stigma reduction and suicide prevention activities. Selective prevention activities are aimed at individuals who may have an increased risk of developing behavioral health conditions (*Mrazek & Haggerty (1994) and Commonwealth of Australia (2000)).*

Potential community members served through increased community education and outreach include, but are not limited to families, local employers including all county and city staff, behavioral, primary, specialty, and hospital health care providers, law

enforcement, and school personnel. Through this effort, SYBH hopes to train thousands of community members. Because the training will be voluntary, and provided with partnership agencies, SYBH's strategy will be to purchase and offer thousands of training hours to thousands of community members through multiple, diverse, accessible community-based venues in a simultaneous deployment of training opportunities both in person and online.

Additionally, SYBH is aiming to train all SYBH staff, a total of 225 employees, and at least 100 local health care providers. This will include staff from the local hospital provider, Adventist Health + Rideout Regional Medical Center, paramedic and ambulance staff. Trainings aimed at healthcare providers will be deployed in collaboration with local Medi-Cal Managed Care health plans and commercial insurance providers. All trainings offered will be culturally competent and include engagement strategies and best practices for ethnically and culturally diverse populations, as well as how to better work with the forensic population.

SYBH's increased community education efforts will include offering training activities focused on how to reach out to individuals with early signs and symptoms of a mental illness and promotion of activities that reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services and to increase acceptance, dignity, inclusion, and support for individuals with mental illness, substance use disorders and members of their families. Trainings will include but are not limited to mental health first aid, community LEAP, Safe Talk, ASSIST, and several trauma informed care trainings.

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

SYBH will be making a change to an existing practice in the field of mental health, including but not limited to, application to a different population, which will be applied in a rural, bi-county setting.

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.*

SYBH has determined the iCARE Team approach is appropriate based on conversations with stakeholders including consumers of SYBH services, family members, law enforcement, emergency room providers, hospital staff, and health and human service providers such as those working in children and family services, probation, and jail settings. Specifically, feedback from stakeholders has been provided to SYBH over the past several years around a common theme related to discomfort of accessing outpatient care after an inpatient or emergency service. Additionally, feedback from stakeholders has included that stigma related to their behavioral health condition is a major factor in their accessing care.

Because of this feedback and rapidly increasing rates of hospital care, SYBH began reviewing data related to the rate at which consumers accessed emergency and crisis services as compared to outpatient care. As described above, the data revealed a significant pattern of crisis and emergency services access without outpatient engagement. SYBH began researching how other counties, behavioral health systems, and health care entities were approaching this same issue.

SYBH reviewed several programs across the nation seeking to increase consumer access, activation and or engagement in health care services for individuals with high hospital and emergency utilization to include:

- **Calaveras County**, Enhancing the Journey to Wellness Peer Specialist Program
- **San Bernardino County**, Recovery Based Engagement Team
- **Camden, New Jersey Coalition of Healthcare Providers,** the COACH Model
- **Department of Health Care Services**, Whole Person Care Pilots - Alameda County Care Connect, Mendocino County – Recovery Oriented System of Care
- **Rural Information Hub, Rural Pennsylvania,** The Behavioral Health Plus Program
- **Rural Information Hub**, **Rural Pennsylvania,** Optimal Health Behavioral Health Home Models
- **Rural Information Hub**, **Rural Michigan**, The Health Belief Model
- **Rural Information Hub, Rural Texas** Collaborative Approaches to Well-Being in Rural Communities

Additionally, SYBH reviewed several published reports and articles to include:

- **Robert Wood Johnson Foundation,** *A Revolutionary Approach to Improving Health Care Delivery, February 1, 2014*
- **US Department of Health and Human Services**, *As Assessment of Innovative Models of Peer Support Services in Behavioral Health to Reduce Preventable Acute Hospitalization and Readmissions, December 2015*
- **ACHMA**, *Peer Services Tool Kit, A Guide to Advancing and Implementing Peer Run Behavioral Health Services, April 30, 2015*
- **World Psychiatry, Official Journal of the World Psychiatric Association,** *Treatment Engagement of Individuals Experiencing Mental Illness: Review and Update, February 2016*
- **Substance Abuse and Mental Health Services Administration (SAMHSA),** *Illness Management and Recovery Evidence-Based Practices, March 2010*
- **German Medical Science,** *Interventions for reducing self-stigma in people with mental illnesses: A systematic review of randomized controlled trials, April 2017*
- **World Health Organization,** Mental Health Action Plan 2013-2020, 2013
- **Georgia Department of Behavioral Health,** The provider Tool Kit for Emerging Adults with Serious Mental Health Conditions, September 2015

Several themes were identified among the programs/articles:

- Trust is key to engagement
- Consumers must see their own goals and vision for themselves in the care being offered
- Care being offered must be patient centered and recovery based
- “Tug of War” scenarios occur when the priorities of care teams don’t align with the priorities of consumers
- Engagement is one of the most powerful tools in increasing and maintaining health and wellness
- Influence occurs through flexibly working with individuals
- Positive relationships with peers enhances engagement
- An individual’s beliefs about their health conditions predict their health-related behaviors
- Disengagement may be related to individuals feeling that treatment is not working, feeling coerced into treatment, or experiencing hardship in accessing services due to services being hard to get to or being hard to schedule
- Individualized strategies that occur out of the office are more effective for those that don’t respond to traditional outpatient therapy
- Traditional mental health settings for some individuals have been linked to alienation and treatment drop out
- Critical time interventions immediately after hospitalization increase engagement
- Efforts that connect with individuals while transitioning levels of care increase engagement
- Stigma can have an impact on help-seeking behavior, treatment adherence, and recovery
- Communities need to work with skepticism, mistrust and local perceptions in order for stigma to decrease and multi sector collaboration to increase
- Trust must be built so stakeholders feel comfortable talking about something as stigmatized and private as mental health

While many practices reviewed focused on engagement as an element of peer run programs, peer support, enhanced case management, self-sufficiency in treatment, or patient “activation” into health care, SYBH is looking to modify the best strategies in all programs reviewed to build a transformative and innovative strategy aimed at engagement as our primary intervention.

Thus, based on feedback from stakeholders including consumers, and review of programs and literature, SYBH has determined that we must work on our relationship with our consumers and community as a priority before influencing an increase in outpatient treatment engagement. As both the LEAP and the COACH model are relational approaches to increased consumer engagement, they have been selected as appropriate interventions to be utilized by the iCare Team.

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

The iCare mobile engagement team is expected to serve 50 individuals at any given point in time, and potentially up to 150 individuals per year. This number was derived by reviewing our total numbers served (5,408), the top utilizers of hospital care (500), total crisis contacts in a year (2,702), and conversations with law enforcement, emergency room staff, consumers, and family members. The number 50 is inclusive of individuals who may need supported engagement in outpatient services and family members who may be ready to engage before their loved ones are ready. Because the engagement process can be long, up to 17 non-clinical contacts, it was important to keep the estimated numbers served appropriate to the needs of those being engaged to allow for the time needed to engage. Additionally, the estimated numbers to be served is based on the amount of available innovation funding per year.

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 iCare Team approach is distinguished first, by the rural setting of both counties that it will be implemented in. San Bernardino County is a large county system with numerous behavioral health resources not present in Sutter and Yuba Counties. Additionally, San Bernardino has engaged in a twelve-year sustained effort to educate county residents on the benefits of behavioral health services with significant investments in infrastructure to include outreach staff, marketing campaigns, media investments and the creation of hundreds of paid peer advocate positions throughout its system of care. The iCARE Team will test if the application of the LEAP model, applied in the context above in San Bernardino, will work in a context in which behavioral health and health resources are scarce and large-scale community education efforts are in an early stage.

Calaveras County is a small California county that has an approved innovation plan as of January 2019 integrating peer specialists into a peer lead case management effort for consumers that experience a high rate of hospitalization. The goal of Calaveras's project per its innovation plan is to, "increase the connection of consumers to existing mental health services and provide housing supports." While SYBH's iCARE team will include strong peer leadership, the iCARE team will not provide case management, and will focus on engagement as its primary intervention. Also, SYBH's iCARE team seeks to change the engagement strategy of current case managers, therapists, psychiatrists and support staff throughout the entire department to more relational-based interactions with consumers for which traditional care is not effective.

The COACH model developed by the Camden Coalition of Health Care Providers is an innovative strategy developed in its earliest form in the 2000's based on the observations of a family physician, Dr. Jeff Brenner, in Camden New Jersey. Specifically, Dr. Brenner noticed that patients habitually frequented the emergency room and hospital inpatient wards for easily treatable conditions but were often seeking care for advanced conditions

that could have been prevented if diagnosed and treated earlier. The COACH model was further developed in 2012 through a collaborative of hospitals, primary health care providers, community providers and social service partners and put into practice at the Camden Coalition in 2014 and codified into a manual in 2016 by the Policy Lab at the Children's Hospital of Philadelphia.

In 2016 Dr. Brenner launched the National Center for Complex Health and Social Needs to share learning and build a movement for complex care. The COACH model targets the hospital to home transition and emphasizes the importance of an authentic healing relationship between care team and consumer that drives behavior change in the utilization of health care services. SYBH would like to explore if the COACH model can be applied to those experiencing severe and persistent behavioral health conditions and train practitioners as empowerment coaches rather than solely providers for consumers. The COACH model, while utilizing some of the practices of behavioral health practitioners, has evolved the tool kit for engagement significantly beyond current practices of most public mental health systems, especially for those with complex medical, social and psychiatric conditions.

The LEAP model was founded by Xavier Amador, a clinical psychologist providing individual, family, child and couples therapy based on his professional experience as a behavioral health practitioner. Dr. Amador's personal experience with a family member suffering from Schizophrenia also influenced the development of the LEAP model. LEAP was initially developed by Dr. Amador to assist health care professionals and family members in "persuading," their loved ones with mental illness to accept services but has evolved to a collaborative communication model focusing on better understanding of consumer experiences.

The LEAP model focuses on assisting professionals with listening to consumers in new ways, transforming the relationship with the consumer first, and emphasizing that practitioner relationships are among the strongest influencing factors for those unable to connect in outpatient care. The LEAP model requires time and flexibility as its most successful intervention, both of which are not routinely available to health care practitioners based on reimbursement and claiming systems supporting health care services. For consumers utilizing high levels of emergency, hospital and crisis care that have no effective connection to outpatient care, through LEAP, it has been found that *time and flexibility is the medicine.*

In speaking with San Bernardino County about the successes and learning from the RBEST project, it was noted that training the entire behavioral health workforce in the LEAP model as well as the engagement team was a critical step they would take if they had the project to do over again. Thus, this is one of the distinguishing features of SYBH's iCARE proposal that is different, as we plan to train all behavioral health staff on the model, as well as several of the physical health care providers at the local emergency room. Additionally, distinctive, will be our use of the COACH care management model perfected in health care settings in conjunction with the LEAP model.

Also, distinctive from rural health practices reviewed by SYBH and implemented in Pennsylvania, Michigan, and Texas, as well as Whole Person Care Practices in the California Counties of Alameda and Mendocino, is the focused emphasis on engagement as the prime or most singularly powerful influencer of health care costs for a group of specific consumers. All other models SYBH reviewed deployed elements of enhanced engagement through case management structures, but the iCARE project will take an opposite approach and deploy elements of transformed case management, or behavioral health care services though an engagement structure.

In reviewing data from the San Bernardino County Department of Behavioral Health's innovation project deployed from 2015-2019, it was noted that consumers who sought care in crisis or hospital systems as a main source of care, and who were unengaged in outpatient care, it took an average of 17 non-clinical contacts before the consumer was willing to come to an outpatient clinic appointment with engagement staff.

Once experiencing a successful outpatient clinic appointment, consumers would typically be accompanied an average of 2 more times to outpatient clinic appointments with engagement staff before consumers felt comfortable enough to attend a clinic appointment on their own. For individuals who had also been chronically homeless and suffered from chronic behavioral health conditions, it took more than 17 non-clinical, trust building contacts and at the top of the range, required up to 70 contacts.

Thus, iCARE will be focusing on changing the system to better address the identified needs for a specific target population for whom the system is not working, instead of forcing the consumer to conform to the needs of the system. Because iCARE's focus is on building trust and improving the relationship with the consumer, the clinical aspects of engagement can be grown in small, flexible intervals, instead of the traditional model requiring the person to engage in structured clinic-based interactions.

The iCARE approach asserts that the time for engagement is the "medicine," influencing a consumer's increased utilization of outpatient care in greater measures when caught in crisis utilization patterns, and not the actual service provided (i.e., case management, medication support services, or therapy). Certainly, case management, medication support and therapy will be provided to consumers, but the measurement of the engagement and it's transformed application will be the factor this innovation project will influence, study and fund. This same philosophy applies to the community education effort funded in parallel to this innovation project through PEI funding, which seeks to engage the community systemically in transformation regarding comfort in accessing and experiencing the benefits of behavioral health care services.

Increasing flexibility for a percentage of consumers circling in crisis and hospital services at a systemic level while still maintaining a structured, standardized system for consumers for which it is working, will be the crux of the iCare Team's challenge. This challenge is at the heart of all current health care reform efforts locally and nationally, and for a percentage of our population, has not yet been figured out. On behalf of those with chronic and persistent behavioral health needs, SYBH, our consumers, stakeholders and

providers believe we can bring considerable insight and learning to this challenge though the iCARE Team – we are ready to transform.

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.*

SYBH reviewed several programs across the nation seeking to increase consumer access, activation and or engagement in health care services for individuals with high hospital and emergency utilization to include:

- **Calaveras County**, Enhancing the Journey to Wellness Peer Specialist Program http://mhsoac.ca.gov/document/2019-01/enhancing-journey-wellness-peer-specialist-program-calaveras-county-innovation-plan
- **San Bernardino County**, Recovery Based Engagement Team,
- http://wp.sbcounty.gov/dbh/mental-health-services/adults/rbest/
  Camden, New Jersey Coalition of Healthcare Providers, the COACH Model https://www.camdenhealth.org/the-coach-model/
- **Department of Health Care Services**, Whole Person Care Pilots - Alameda County Care Connect, Mendocino County – Recovery Oriented System of Care
  https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC%20Narrative%20Reports/Alameda_2017_Annual_Narrative_Report.pdf
  https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC%20Narrative%20Reports/Mendocino_2017_Annual_Narrative_Report.pdf
- **Rural Information Hub, Rural Pennsylvania,** The Behavioral Health Plus Program https://www.ruralhealthinfo.org/project-examples/901
- **Rural Information Hub**, **Rural Pennsylvania,** Optimal Health Behavioral Health Home Models https://www.ruralhealthinfo.org/project-examples/1022
- **Rural Information Hub**, **Rural Michigan**, The Health Belief Model https://www.ruralhealthinfo.org/toolkits/health-promotion/2/theories-and-models/health-belief
- **Rural Information Hub, Rural Texas** Collaborative Approaches to Well-Being in Rural Communities https://www.ruralhealthinfo.org/project-examples/1048

Additionally, SYBH reviewed several published reports and articles to include:

- **Robert Wood Johnson Foundation,** *A Revolutionary Approach to Improving Health Care Delivery, February 1, 2014* https://www.rwjf.org/en/library/articles-and-news/2014/02/improving-management-of-health-care-superutilizers.html
- **US Department of Health and Human Services**, *As Assessment of Innovative Models of Peer Support Services in Behavioral Health to Reduce Preventable Acute Hospitalization and Readmissions, December 2015 https://aspe.hhs.gov/system/files/pdf/205411/PeerSupServ.pdf*

- **ACHMA**, *Peer Services Tool Kit, A Guide to Advancing and Implementing Peer Run Behavioral Health Services, April 30, 2015* *https://www.mentalhealthamerica.net/sites/default/files/Peer_Services_Toolkit%204-2015.pdf*
- **World Psychiatry, Official Journal of the World Psychiatric Association,** *Treatment Engagement of Individuals Experiencing Mental Illness: Review and Update, February 2016* *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4780300/*
- **Substance Abuse and Mental Health Services Administration (SAMHSA),** *Illness Management and Recovery Evidence-Based Practices, March 2010* *https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/sma09-4463*
- **German Medical Science,** *Interventions for reducing self-stigma in people with mental illnesses: A systematic review of randomized controlled trials, April 2017* *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5404117/#R1*
- **World Health Organization,** Mental Health Action Plan 2013-2020, 2013 https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=AEA76B5C814F4670525306F63187CFDC?sequence=1
- **Georgia Department of Behavioral Health,** The provider Tool Kit for Emerging Adults with Serious Mental Health Conditions, September 2015 *https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/HTI%20Toolkit%209.10.15.pdf*
- **Health Services Research, Development of the Patient Activation Measure (PAM)**: Conceptualizing and Measuring Activation in Patients and Consumers, August 2004 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/
- **Administrative Policy Mental Health**, Development of the Patient Activation Measure for Mental Health (PAM-MH), June 2010 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3536445/
- **Frontiers in Psychology**, Measuring Patient Engagement; Development and Psychometric properties of the Patient Health Engagement Scale (PHE), March 2015 https://www.frontiersin.org/articles/10.3389/fpsyg.2015.00274/full
- **Consortium for Patient Engagement,** *Measuring Patient Engagement: A Must for Effective Health Care Reform*, January 2016 http://cope.tips/measuring-patient-engagement-a-must-for-effective-healthcare-reform/

While significant information exists in practice and health care literature on the impact of improved case management practices, with elements of engagement embedded in the case management model including patient activation, there is little developed research on the effects of engagement in behavioral health as a single factor influencing consumer access to care, quality of services, and costs related to inadequate utilization of care.

Per an article published in August 2004 in Health Services Research, “Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and consumers,” researchers convened a national expert consensus panel and multiple patient focus groups to define the concept of “activation” and identify the domains of activation. The study resulted in a 100-point patient activation scale determining patient engagement in health care.

After over a decade of use the PAM has been validated in the United States and some countries. In August 2009 the PAM was updated to adapt it’s use among individuals with mental health conditions resulting in the PAM - MH. In an article published in Administrative Policy in Mental Health in 2010 on the use of the PAM-MH in three studies for 230 individuals, results indicated that the PAM-MH is a valid and reliable measure of activation among individuals with mental health conditions, but that greater activation was related to, “higher levels of recovery, better mental health care, better physical and mental health, and fewer mental health symptoms.” This suggests that study participants utilizing the PAM-MH were already engaged. Furthermore, the PAM-MH does not appear to be widely used or represented in the literature as to its use beyond the initial documented study in 2009.

Per an article published in Frontiers in Psychology, March 2017, “Measuring Patient Engagement: Development and Psychometric Properties of the Patient Engagement (PHE) Scale,” the “PAM is a powerful instrument able to detect the level of activation of patients towards their care management.” Furthermore, the article asserts that, “Although the concepts of ’activation’ and ’engagement’ have some areas of conceptual overlapping, they differ according to the breadth of the health care considerations related. The concept of ’activation’ is mainly limited to the prototypical situation of doctor-patient consultation while the concept of ’engagement’ seeks to consider multiple levels of the patients’ fruition of the healthcare.” The article goes on to state that current practices devoted to improving patient engagement in healthcare management suffer from a lack of shared guidelines to achieve this goal and confusion exists about what patient engagement is and how it may be conceptualized and achieved.

Per an article published on the Consortium for Patient Engagement, “Growing acknowledgement is played to the emotional and psychodynamic components of the patients’ illness experience that appears to be the first movers of the patients’ confidence and ability to acquire information about their health status and to master self-management of behaviors. The emotive component of engagement, conceived as the patients’ process of elaboration and adjustment to the disease, is also being demonstrated to be a crucial mediator of patients’ activation and adherence.”

In the literature there is consensus and emerging conversation about distinction of engagement as an element of activation, or a stand-alone factor from activation

that requires further research. Thus, a gap in the literature exists on the impacts of engagement in general, and even more so for behavioral health conditions.

Evaluation of this innovation project will attempt to achieve a focused study on how levels of engagement impact utilization of health care services for those with behavioral health conditions and lead to the generation of substantive and meaningful research advancing the theory, practice and understanding of engagement.

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?*

Through this new innovation project, SYBH will focus on the following key learning questions:

1) Will the implementation of a flexible, mobile engagement team trained in the LEAP and COACH models result in increased outpatient utilization of services (increased access to care), including SUD treatment, for consumers utilizing crisis and emergency services as their main source of care?
2) Will training a field-based engagement team as well as all SYBH staff in the LEAP and COACH models lead to increased levels of consumer engagement evidenced by consumer self-report, and patient activation and engagement measures?
3) Will the implementation of a flexible, mobile engagement team trained in the LEAP and COACH models result in a decrease in the number of behavioral health related calls to law enforcement?
4) Will the implementation of a flexible, mobile engagement team trained in the LEAP and COACH models result in a reduction in the 5150s brought to the emergency room?
5) Will the implementation of increased community education trainings aimed at increasing the knowledge of behavioral health treatment benefits create an increased level of comfort in accessing behavioral health services?
6) Will family members and caregivers who ordinarily don't know much about chronic behavioral health conditions increase their knowledge of coping skills, support strategies and understanding about how to support their loved ones who are accessing the behavioral health system?

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

Through the iCARE Team, SYBH would like to understand if the utilization of transformed engagement practices through the LEAP and COACH models will increase outpatient utilization of services (increased access to care) for consumers utilizing crisis and emergency services as their main source of care. Through this engagement effort, SYBH would like to understand if consumers are more able to engage in outpatient behavioral health care or substance use treatment services, and if they experience an increased quality of care, knowledge of their condition, and feel better able to manage their condition utilizing outpatient care.

SYBH would also like to understand if engagement practices at every level of the organization, and the emergency room, can be transformed through training with the LEAP and COACH models. At the community level, SYBH would like to understand if community level training regarding the benefits of behavioral health services will result in an increase in comfort in accessing behavioral health care and increase the general knowledge of community members related to behavioral health care, to include early signs and symptoms of behavioral health illness.

SYBH as a rural county mental health plan would like to contribute to emerging research and study of the impact of engagement, further defining engagement activities and definitions, quantifying engagement using scales such as the PAM-MH, the PHE and others that may be developed or identified. If successful, this project will significantly contribute to the potential for changed practices in behavioral health care, physical health care, care management and care coordination at both the state and national levels.

The learning goals as detailed above have been developed based on community and stakeholder input, including consumers with lived experience, review of SYBH service and access data related to crisis, emergency, hospital and outpatient use, law enforcement and emergency room data, and the current prevalent research in patient engagement as it relates to health care utilization and increased quality of care. Additionally, these goals have been developed based on the need for a more flexible and effective service response to consumers in a “go to” model, community partners and the community at large.

Lastly, SYBH seeks to learn how to better incorporate stakeholder participation in program development, to include the implementation of the iCARE Team through a partnership with the patient centered outcomes research institute (PCORI) under this innovation project. The PCORI was established to fund research that can help patients and those who care for them make better-informed decisions about the healthcare choices they face every day, guided by those who will use that information. Specifically, the mission of PCORI is to improve health care delivery and outcomes by producing and promoting evidence-based information from stakeholder guided research. SYBH’s goal will be to use PCORI’s engagement planning tools for effective engagement of consumers and stakeholders in the implementation, evaluation and research design of the iCARE Team innovation project.

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.

SYBH will measure iCARE Team success using both process and outcome indicators. Process indicators measure the extent to which the project was implemented as intended, while outcome measures will provide information on the effect of the project on consumers, the mental health system and the community overall. SYBH, in partnership with evaluators, including stakeholders, will identify/confirm data points and the evaluation methods below to measure project implementation and impact.

Data points may include baseline data regarding utilization of services, consumer, family member and community surveys. Evaluation activities will aim to address the key learning questions of the project. The following table outlines the data to be collected (i.e., measurement metrics) and potential data sources listed by their respective key learning question. An evaluation plan with a timeline, deliverables, metrics and implementation specifics will be further developed through stakeholder engagement sessions utilizing an engagement plan from PCORI that outlines how stakeholders will be involved in all aspects of the evaluation.

ICARE TEAM LEARNING FRAMEWORK

Learning Question	Outcome	Measurement Metric	Data Source (s)
1. Will the implementation of a flexible, mobile engagement team trained in LEAP and COACH models result in increased access to care for outpatient utilization of services, including SUD treatment for consumers utilizing crisis and emergency services as their main source of care?	§ Increased utilization of outpatient behavioral health care services for underserved groups § Decrease in homelessness	Change in (increase or decrease) of Behavioral Health Services delivered by the Mental Health Plan from baseline when available including: • Individual therapy • Group Therapy • Collateral • SUD Outpatient • Medication Support • Case Management • Crisis intervention • Crisis Stabilization • SUD Residential Treatment • Inpatient Hospital Care Number of consumers engaged that received housing support	SYBH Medical Record and Claiming System MORS PES Service LOG Training Evaluations for LEAP and COACH Model Continuum of Care Database Consumer Report
2. Will training a field based engagement team as well as all SYBH staff in the LEAP and COACH models lead to increased levels of consumer engagement	§ Increased consumer engagement § Increased family	To be further defined with consumers/stakeholders: • Level of disengagement	Patient Activation Measure (PAM) Survey Patient Activation Measure – MH Survey

evidenced by consumer self-report, and patient activation and engagement measures?	support and/or engagement with consumer recovery and wellness	• Elements of disengagement • Becoming engaged but still struggling • Taking action • Maintaining Engagement and Pushing Further	COACH dominant core needs survey Patient Health Engagement (PHE) Scale
3. Will the Implementation of a flexible, mobile engagement team trained in LEAP and COACH models result in a decrease in the number of behavioral health related calls to law enforcement?	§ Decreased Hospitalizations § Decreased abuse of alcohol and illegal drugs	• Number of 5150 evaluations • Number of Psychiatric Emergency Services (PES) • Number of hospitalizations • Number of days hospitalized • Number of Emergency Room visits • Number of emergency room visits which have not led to hospitalization • Number of co-occurring diagnosis consumers with PES/ hospitalizations • Number of substance abuse/misuse episodes/relapse (e.g. use of drugs or alcohol beyond a slip, that goes unaddressed and did not get immediate attention)	SYBH Medical Record and Claiming Systems PES Service LOG Law Enforcement Call Logs
4. Will the implementation of a flexible, mobile engagement team trained in LEAP and COACH models result in a reduction in the 5150's brought to the emergency room?	§ Decreased Emergency Room visits §Decreased PES visits	• Number of 5150 evaluations • Number of Psychiatric Emergency Services (PES) • Number of hospitalizations • Number of days hospitalized • Number of Emergency Room visits • Number of emergency room visits which have not led to hospitalization	Cerner Hospital Medical Record and Claiming System SYBH Medical Record and Claiming Systems PES Service LOG

		• Number of co-occurring diagnosis consumers with PES/ hospitalizations • Number of substance abuse/misuse episodes/relapse (e.g. use of drugs or alcohol beyond a slip, that goes unaddressed and did not get immediate attention)	
5. Will the implementation of increased community education trainings aimed at increasing the knowledge of behavioral health benefits create an increased level of comfort in accessing behavioral health services?	§Increased community awareness of behavioral health services §Increased awareness of behavioral health knowledge §Increased comfort in accessing behavioral health care	To be further defined with consumers/stakeholders: • Level of information received from trainings about behavioral health conditions • Level of information received in training about what to do access behavioral health services • Level of information provided to care givers from mental health professionals • Level of satisfaction with information received	Community Training Evaluations Community Engagement Surveys Family Engagement and Intervention Survey (FEIS) Focus Groups
6. Will family members and care givers who ordinarily don't know much about chronic behavioral health conditions increase their knowledge of coping skills, support strategies and understanding about how to support their loved ones accessing the behavioral health system?	§Increased community awareness of behavioral health services §Increased awareness of behavioral health knowledge §Increased comfort in accessing behavioral health care	To be further defined with consumers/stakeholders: • Level of information received from trainings about behavioral health conditions • Level of information received in training about what to do access behavioral health services • Level of information provided to care givers from mental health professionals • Level of satisfaction with information received	Community Training Evaluations Community Engagement Surveys Family Engagement and Intervention Survey (FEIS) Focus Groups

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?

SYBH plans to contract out the project in three distinct project areas:

1) The iCARE Team is a hybrid model that integrates contractor leadership and iCARE staff into the ongoing operations of SYBH. This contract will include the mobile field-based engagement team, including all staff and engagement team related costs and will be overseen by SYBH program managers for Acute Psychiatric and Forensic Services and Adult Services. The iCARE Team members will attend routine meetings with SYBH as determined, including iCARE regularly established operations meetings lead by SYBH and will include consumers, law enforcement representatives, hospital staff, and other community partners. Contractors may include non-profit, community-based agencies or groups with the expertise in health and human services needed to provide required services.
2) The evaluation portion of the iCARE project will be contracted out to a qualified evaluation vendor and will be overseen by the Branch Directors for Acute Psychiatric and Forensic Services and Adult Services. Contractors may include qualified university, community based or data analytics vendors.
3) The organization of the LEAP, COACH and community training efforts will be contracted out and overseen by the Branch Directors for Acute Psychiatric and Forensic Services and Adult Services and managed by the MHSA coordinator. Community training contractors may include Yuba College, UC Davis, and other community-based training vendors, as well as training vendors not local to the region such as the LEAP institute and the Camden Coalition.

The iCARE Team and related contracts will be included in SYBH's routine and customary contract monitoring and review processes staffed by contract analysts, and SYBH's administrative and fiscal officers and will be further monitored by branch directors and the MHSA coordinator. Additionally, SYBH will utilize the expertise of a fiscal consultant in reviewing the expenditures of MHSA, including innovation funding.

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.

Through the community's local newspaper, The Appeal Democrat, and other resources such as the Sutter and Yuba County One-Stops, Sutter and Yuba County libraries, Sutter and Yuba County Administrative Offices, Facebook, email blasts, and flyers posted at all service sites, SYBH posted information on how to attend a community planning session. SYBH hosted four public planning sessions as follows:

In Sutter County: Thursday, April 25, 2019, 3:30 – 4:30 pm and Thursday, April 25, 2019, 5:00 – 6:00 pm at Veteran's Hall – Tucker Room 1425 Veterans Memorial Circle, Yuba City.

In Yuba County: Tuesday, April 30, 2019 3:30 – 4:30 pm and Tuesday, April 30, 2019 5:00 – 6:00 pm at Yuba County Government Center, Board of Supervisors Chambers 915 8th Street, Marysville.

Additionally, SYBH hosted 10 targeted stakeholder forums as follows, including one session in Spanish:

1) Homeless Union – April 23, 2019 12:00 – 1:00 pm
2) Yuba County Health and Human Services – April 24, 2019 10:00 – 11:00 am
3) Wellness and Recovery Town Hall – April 29, 2019 9:30-10:30 am
4) Latino Outreach Center – April 29, 2019 2:30-4:30 pm
5) Yuba County Law Enforcement and Adventist Health + Rideout Hospital (including emphasis on Emergency Room Staff) – April 30, 2019 11:30 am – 1:30 pm
6) Sutter County Law Enforcement Staff – May 2, 2019 2:00 – 3:00 pm
7) Behavioral Health Advisory Board – May 9, 2019 5:00 – 6:00 pm
8) Family Member Support Group – May 9, 6:00- 8:00 pm
9) Hmong Outreach Center – May 21, 2019 10:00 – 11:00 am
10) Sutter Emergency Operations Center – June 14, 11:00 am – 12:00 pm

A total of 14 stakeholder meetings were held. All sessions included stakeholders with interest in behavioral health services in the State of California, including but not limited to individuals with behavioral health conditions, and/or their family members, providers of behavioral and physical health care, social services, educators or representatives of education, law enforcement and other organizations representing interests of those with behavioral health care needs.

As of the posting of this draft plan SYBH has received feedback from 95 stakeholders attending stakeholder meetings. Of those who attended, 84 filled out stakeholder feedback forms. While not all questions on all forms were answered, of those that were, the demographics for stakeholders attending stakeholder meetings are as follows, including a rating of the CPP process itself.

Of those who attended the stakeholder meetings and completed a stakeholder comment form, 82% of respondents were between the ages of 26-59, 15% were age 60 and older, 32% were male and 64% were female. 46% of respondents reported being from Yuba County, while 46% of respondents reported being from Sutter County. 21% of respondents reported they are a family member of someone with a behavioral health issue, 10% reported they are a consumer, 6% reported they are law enforcement, 1% reported attending for an educational purpose, 9% were from a community agency, 2% were from a faith community, 11% were County staff, 6% were from a social service agency, 3% were from a healthcare provider, 20% were community members, 2% were

active military/veterans and 2% were alcohol and drug providers. 27% of respondents identified as Latino, 2% identified as African American, 39% identified as Caucasian, 19% identified as Asian/Pacific Islander, 5% identified as American Indian and 11% stated Spanish is their primary language.

60% of stakeholders who completed feedback forms indicated they were very satisfied with the Community Program Planning Process, while 30% reported they were satisfied and 5% reported being somewhat satisfied, for a total of 90% of stakeholders being either satisfied or very satisfied with the Community Program Planning Process for the ICARE innovation plan.

The draft innovation plan was publicly posted on Sutter County's website from May 6 – June 5, 2019. Additionally, the link to the publicly posted plan was emailed to approximately 391 stakeholders, including individuals participating in stakeholder meetings that provided email addresses to SYBH. The link to the publicly posted draft plan was sent out via email to all Health and Human Services staff in both Sutter and Yuba Counties, law enforcement, and Adventist Health + Rideout Regional Medical hospital staff.

Two press releases noticing the posting of the plan was sent to the local newspaper with a full article detailing stakeholder meeting dates and the process for the posting of the plan published in the local newspaper, the Appeal Democrat, on April 14 and April 28, 2019. Flyers posting the dates of the public hearings were posted at Sutter-Yuba Behavioral Health (SYBH), SYBH's Latino Center, Hmong Center, Public Health, the County Administrator's offices for both Sutter and Yuba counties, both Sutter and Yuba County libraries, and other various county buildings in the two counties. Additionally, the iCARE Stakeholder meeting flyers were shared on Sutter County's Network of Care Website on April 18, 2019 in addition to email blasts also being sent out to Sutter and Yuba County employees and five additional non-county agencies on April 18, 2019.

While no written comments were received during the time the plan was publicly posted, (May 6, 2019 – June 5, 2019), several verbal comments and one email comment were provided to SYBH in addition to written comments via stakeholder feedback forms collected at stakeholder meetings. Written comments as provided by stakeholders via stakeholder comment forms and submitted during stakeholder meetings are included in this proposal in the stakeholder's own words in the appendices. Additionally, a summary analysis of comments received is as follows.

Verbal comments included requests for SYBH to clarify in the innovation project narrative how family members will be noticed of the existence and availability of the iCARE Team including how referrals could be made. Additional clarification was also requested as it related to the number of training hours to be offered, number of community members, SYBH staff, and health care providers projected to be trained under this effort. Stakeholders requested trauma informed trainings be added to the roster of trainings offered and that trainings be offered to EMTs and paramedics providing care in ambulance response. Suggestions were made to offer trainings to local business owners

to include convenience stores, gas stations and laundry mats. Clarifications for referrals, family outreach and additions for types of trainings, and recipients of training have been made to include all suggestions above in the section of this proposal titled, *proposed project, section A.*

In the law enforcement stakeholder session, it was verbally noted that, “There is more stigma for community members in receiving mental health care than getting arrested,” and there was hope through the community training component of this plan that this stigma could be reduced.

Verbal suggestions also included an emphasis on cultural and language competency to include competencies in working with forensically involved consumers. These suggestions have also been incorporated in the training offerings under this plan and included for implementation of the project.

While this project will serve adults 18 years old and older, several stakeholders requested that SYBH consider if a mobile engagement team like the iCARE Team could work for children and youth. While SYBH did not change the age range to be served by the iCARE Team in this innovation project, SYBH will keep this request in mind as we study the engagement strategy under this project, as well as other MHSA programs focused on serving children and youth.

Other comments highlighted the value of paid peer mentor positions within county mental health plans, to include a suggestion for integrating paid peer mentors within local Red Cross programs. While this project will not integrate paid peer mentors within local Red Cross programs, SYBH acknowledges the value that peer mentors could bring to the Red Cross. SYBH will include the Red Cross in the group of community partners to which community training will be offered. SYBH will also offer a community presentation about what the iCARE team does and how to refer to the local Red Cross. Paid peer mentor positions are included in this proposal as integral members of the iCARE mobile team.

Additionally, verbal and written comments provided by stakeholders, both in direct quotes and in summary points as discussed in stakeholder meetings are detailed below. No changes to the publicly posted plan were required as comments were in alignment with the plan. Some comments as listed below are direct quotes and others are summarized from stakeholder conversations.

Support for the benefits of, “Training of outside systems to better support individuals with behavioral health needs.”

“Working with Law Enforcement to ensure measurement of engagement of forensically involved consumers, specifically those with substance use treatment needs.”

“Better educating first responders including ambulance staff about behavioral health conditions and working with community members needing care.”

“Ensuring the iCARE Team was collaborating and coordinating with the Rideout street medicine team and physical health care providers to include the emergency room.”

“Meeting consumers where they were.”

“Building trust and respecting consumers as people.”

“Partnering with consumers in ways that have a balance of power and allow for true partnership in behavioral health care.”

“Partnering with consumers in ways that allow for dignity.”

“Understanding that consumers don’t want to be, “owned by the behavioral health system.”

“Address consumer transportation needs.”

“NAMI or increased family supports should be present in the community.”

“Peer positions can, “show other consumers the ropes,” or “let new consumers know they got a lot of help here at SYBH.”

“Have engagement approaches that allow consumers to, “develop their own personal check list for insight,” and read books on behavioral health conditions on their own terms.”

“Deploy the mobile team in ways that respect consumer rights and liberties.”

“Deploy the mobile team in non-descript ways that don’t increase the stigma of behavioral health.”

“Respect community neighborhoods by coming there but maintaining confidentiality and anonymity - Don’t put SYBH or the county logo on the van.”

“Ensure peer positions incorporated in iCARE team are paid positions.”

“Respect the time of health care providers whose skill sets are greatly impacted because of severe provider shortages.”

“Ensure the innovation project includes the homeless community, to include the collaboration with the homeless union and peers with lived experience in the deployment of the project.”

“Family members trying to access care and encountering barriers find those barriers traumatizing and feel, “There MUST be something better than this,” of experiences with 5150’s for loved ones.”

In summary, there was overwhelming support for both aspects of the innovation proposal with an overwhelming majority of stakeholders saying the mobile team and wide-reaching community education strategy has been, “needed for years,” and that better engagement strategies were “crucial.”

Stakeholders commented the proposal was, “Spot on,” with consumers stating that the proposal “did better than they expected,” in recognizing needs.

Stakeholders also commented that the proposal sounded, “too good to be true,” and they hoped it was successful.

While clarifying language was added to the innovation proposal as indicated above and in response to consumer and stakeholder requests, no substantive changes to the proposal or publicly posted plan were made.

Consumers, family members, community partners, service providers, and educational partners helped Sutter-Yuba Behavioral Health with the program planning process for this project, and will continue to help with program implementation, monitoring, quality improvement, and project evaluation.

Additionally, if approved, SYBH will create an innovation operations committee comprised of family members, consumers, stakeholders, community representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial composition of the two counties to be involved in the implementation, evaluation and operation of the project.

MHSA GENERAL STANDARDS:
The iCARE Project will be planned for and implemented in ways that are consistent with the general standards and core values of the Mental Health Services Act and Title 9, CCR, section 3320, including the values of community collaboration; creating an integrated-service experience; promoting wellness, recovery, and resiliency; creating a consumer and family-driven mental health system; and creating a culturally competent system of care.

A) Community Collaboration:
The iCARE Team Innovation Project initiates and supports a collaborative relationship between consumers, family members, Sutter-Yuba Behavioral Health, Yuba County Sheriff’s Department, Sutter County Sheriff’s Department, Marysville Police Department, Yuba City Police Department, local Highway Patrol, Live Oak Police Department, and other agencies such as emergency department staff, hospital inpatient staff, probation departments, local shelter/housing authority, food banks, and other social service systems.

In partnering with stakeholders, SYBH has established a shared vision and goals for the iCARE innovation project. SYBH will work with and learn together with stakeholders regarding how SYBH can provide consumer centered care and improved outcomes for individuals who have not been successfully connected in the public mental health system but have chronic behavioral health needs that are often only addressed through emergency, hospital care, or law enforcement. Additionally, if successful, SYBH would

like this model of collaborative engagement, to include the community training portion, to be replicated by other counties and health care systems.

B) Cultural Competency:

The innovation project targets underserved populations and the uniqueness of individuals that aren't engaged with the public mental health system but have chronic behavioral health needs. The iCARE Team innovation project is focused on addressing challenges and needs by finding the best approach to target outreach and services in a culturally competent manner. Additionally, project measurements and evaluation efforts will include data by gender, race/ethnicity, linguistic categories, religious preferences and other cultural factors to help us learn/utilize strategies or approaches that are effective within specific groups and targeted populations.

SYBH is committed to providing cultural competence training to ensure a culturally competent workforce. Training plan goals aim to increase cultural competence skills and knowledge at all levels of Sutter-Yuba Behavioral Health. Additionally, Sutter-Yuba Behavioral Health's mission statement, policies, procedures, and organizational culture demonstrate a commitment to cultural competence. All new employees, including new staff hired through the iCARE Team Innovation Project will participate in an employee orientation that describes their staff responsibilities, to further drive SYBH's mission to provide services to the community in a manner that is culturally appropriate.

Services provided by the iCARE Team will be subject to review by the SYBH Cultural Competence Committee. This subcommittee of the Quality Improvement Council reviews SYBH policies and practices to ensure that services are provided in a way that is culturally and linguistically competent, including adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) for health and health care.

C) Client-Driven:

The iCARE Team Innovation project is driven by the needs of consumers. The communities served by SYBH face multiple challenges specific to rural northern counties, specifically, minimal connections with current outpatient systems, and stigma as a result of experiencing a behavioral health condition. In the creation of this project, SYBH spoke with over 50 consumers of behavioral health care and 12 family members. Consumers shared their support for this project, specifically stating that sometimes accessing behavioral health services, including hospital care, feels like, "I'm here to surrender my dignity. I don't want to surrender, I want a partner in my treatment."

The LEAP and COACH engagement models are consumer focused and work on first building trust and understanding about how the consumer sees their own health care conditions, needs and treatment plans. The project allows the iCARE

team to take the time necessary, which is not currently available in our system of care, to address goals related to health care in a flexible way. It further studies the impact of this flexibility on increased access and quality of behavioral health care. The iCARE team approach will allow consumers to drive systemic changes in the public behavioral health system and local community, transforming our current system of care, by embedding engagement practices that make consumers feel "welcome" and "invited." Additionally, this project will aim to support the community in understanding behavioral health care needs, signs and symptoms, and supportive resources, thereby collectively raising wellness awareness in the community, decreasing stigma and directly impacting a consumer's experience of behavioral health care in the communities in which they live and work.

D) Family-Driven:

The iCARE TEAM Innovation project will also work with family members to increase knowledge, awareness and coping skills in supporting a loved one with chronic behavioral health conditions. In many cases, chronic behavioral health conditions can last the lifespan of a loved one, and while recovery and wellness is possible, family members often lack the tools and information necessary to best assist in their loved one's recovery. This includes an understanding of the etiology or development of the condition, current interventions and treatments, the chronicity of conditions and tools to assist in the ongoing care of their loved one. Specifically, this project seeks to concurrently increase, strengthen and educate community, social and familial support systems of those living with chronic behavioral health conditions.

E) Wellness, Recovery, and Resilience-Focused:

The iCARE TEAM Innovation Project plans for and promotes an approach that is reflective of the philosophy, principles, and practices of the recovery vision for consumers. The primary purpose of this project is to increase the quality of services, including improved outcomes for persons living with one or more chronic behavioral health conditions. SYBH expects the iCARE Team Innovation Project to result in improved outcomes for Sutter and Yuba counties' populations and improved community recognition of the principles and possibilities of behavioral health wellness and recovery. These results will be measured through increased levels of engagement in outpatient care, decreased levels of stigma, increased levels of wellness, and increased levels of knowledge for family and community support practices related to resiliency, and wellness and recovery for individuals with chronic behavioral health needs.

F) Integrated Service Experience for Clients and Families:

The iCARE Team Innovation Project is designed to include a higher level of coordinated care for both consumers and families through increased engagement. The engagement models, LEAP and COACH, seek to integrate engagement efforts after key events, with the outpatient system of care resulting in an improved treatment experience for consumers. Specifically, the iCARE project seeks to better integrate the consumer experience at key transition points from inpatient or

psychiatric emergency care, to outpatient care, in a manner that allows the consumer to feel accessing outpatient care is easy, effective and meeting their needs. Additionally, the iCARE project seeks to integrate family members, with consumer permission, in consumer treatment planning sessions and psychoeducation. For those family members that do not receive their loved one's permission to be more closely integrated in their care, the iCARE team will work to provide support and psychoeducation that will increase the family members' knowledge of the public behavioral health system, services and supports.

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 iCARE Team Evaluation Plan was developed in accordance with SYBH's Cultural Competence Plan – updated December 2018. SYBH provided interpretation services at each of the public stakeholder sessions and held one session entirely in Spanish to include all written material and spoken discussion. SYBH also hosted a stakeholder session at the Hmong Center in which the presentation was interpreted in Hmong. SYBH will utilize the feedback gathered in stakeholder sessions to ensure the approach of the mobile engagement team and community education efforts are culturally competent. Members from the Cultural Competence Committee will be invited to sit on the innovation implementation/operations committee which will review iCARE policies, trainings and operational program elements. Per MHSA requirements - WIC section 5848, subdivisions (a) and (b) and CCR, Title 9, sections 3300 and 3315, the iCARE Team Innovation Plan was developed with local stakeholder involvement and made available in draft form and then circulated for review and comment for the minimum 30 days to representatives of stakeholders, and any party who requests a copy of the document.

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 on what is learned during the evaluation of the iCare team project, SYBH will consider funding successful elements of the innovation project in whole, or in part, with the following funding sources:

- DHCS pilot projects as defined under the 1115 waiver renewal, 1915(c) waiver renewal or other care coordination projects funded at the State level such as whole person care, or health homes.
- Mental Health Services Act (MHSA) funding, specifically Community Services and Supports (CSS) and Prevention and Early Intervention (PEI)
- Medi-Cal for activities determined to be eligible for Medi-Cal reimbursement

- Quality Improvement Collaboratives with or service contracts with local Medi-Cal Managed Care Plans or Commercial Insurance Plans
- Hospital Based and/or Community Based Grants or Funding
- Grant Funding

As learning will be concurrent with the implementation of the innovation project, planning for sustainable funding of successful elements will begin immediately upon approval of the innovation plan.

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?*

Project updates will be provided at monthly innovation implementation/operations committee meetings, which will include stakeholders as well as quarterly MHSA community program planning meetings. These will address progress, goals, expected outcomes, and the overall approach of the iCARE project.

SYBH will also work with both Sutter County and Yuba County Public Health and Social Service Departments, as well as other community groups to discuss how SYBH can disseminate education on iCARE, specifically regarding family support and stigma reduction. Additionally, SYBH will provide numerous targeted community presentations of the project to community groups, service providers, law enforcement, fire, local colleges, and other significant partners, to include how to refer to the mobile iCARE Team.

SYBH will work with local newspaper and media outlets, including social media, to advertise, market and promote community trainings. These efforts will include working with local employers, church congregations, community groups, and other social organizations to deploy community trainings via employee learning systems, in community venues or through other structures where training and public information can be deployed.

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. Mental Health
2. Alcohol and Drug Treatment
3. Help
4. Support
5. Behavioral Health

TIMELINE:

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

The tentative start date for the iCARE project is August 1, 2019 or as soon as MHSOAC approves the use of Innovation funds to fund and begin this project. The end date is scheduled for five years from the start date; e.g., if the CARE project is approved 08/01/2019 the end date will be 07/30/2024, with the final INN report completed six months from end of project date.

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

Five years, tentatively August 1, 2019 – July 30, 2024, final report by December 2024.

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

The project is expected to last five years and will consist of three phases. The project will begin upon approval (potentially in August of 2019), with an end date in July 2024.

Phase 1: August 2019 – March 2020 (first eight months): Contractors for the mobile engagement team, evaluation of the innovation project and community training will be sought. Training will be provided to all of Behavioral Health and the iCARE team members utilizing Dr. Xavier Amador, founder of the LEAP Institute specializing in engagement practices and Dr. Jeffrey Brenner's Camden COACH Model specializing in coaching techniques to empower consumers in shaping their treatment engagement. Non-violent Crisis Intervention training and Motivational Interviewing will also be provided to the iCARE team. Policies and procedures will be created for the delivery of mobile engagement practices. Staffing, to include peer hiring practices, equipment, supplies, and vehicles will be secured during this first phase. Staff will become familiar with the region, resources, and collaborative partners. The evaluation model will be collaboratively developed with the involvement of stakeholders. Community presentations to community groups on how to refer to the iCARE mobile team will be completed. The stakeholder driven evaluation model will be created, and the implementation/operations committee established.

Phase 2: March 2020 – January 2024 (three years and 8 months): The middle phase of the project will be devoted to full implementation of the services outlined in this project description. The team will be deployed in the Sutter and Yuba areas and will provide field-based services. Modifications will be made to the project as learning occurs. Program evaluation information and data will be collected on a regular and to be determined basis, evaluated continuously, and will be shared at monthly implementation/operations committee meetings, quarterly MHSA Program Planning Meetings and integrated with the work of the project analyst contracted through Kings View and servicing SYBH's medical record. Significant amounts of community training hours will be offered, tracked and measured.

Phase 3: January 2024 – July 2024 (six months): During the last six months of the project, SYBH will evaluate all of the data collected and make a final determination of the project's success. However, project evaluation will be continuous and occur from day one of the project. To allow for appraisal of the iCARE project, the numbers of consumers served may be reduced in the last six months of the project. All consumers receiving care will be provided appropriate transitional and continuity of care based on their individual needs.

If plans are made to sustain the project or integrate it into current clinical operations because of the learning obtained during this project, staff will work with the consumers receiving services through the project to integrate fully into continued services.

It is anticipated that this timeline and sample population will provide an adequate opportunity to measure the project's success. Data will be collected throughout the implementation of the project and analysis of progress towards the learning goals completed. This will allow for modification to the project as necessary as learning occurs.

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 amount associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The total requested innovation project expenditures are $5,939,288 over 5 years including both Innovation and PEI funding. The iCARE Project will initially use AB114, MHSA Reversion funds from prior years. Once the initial Reversion Funds of $1,575,878 have

been spent, additional Innovation Funds that are subject to Reversion in the amount of $1,252,810 will be used, and lastly the ongoing Innovation funds for FY 2019-20 through FY 2023-24 will be used. In addition, it is projected that MHSA PEI Funding will be utilized that is at risk of reversion to integrate into this project for community-based training.

Direct costs will total $3,979,838 over the 5-year project and will include fuel, supplies, and support and care costs for consumer outreach and engagement. Indirect costs total $1,637,600 over the 5-year project, which include rent and utilities, LEAP, COACH, and Community-based Trainings and $500,000 dedicated to Project Evaluation. This Indirect Cost budget also includes contracted evaluation costs and anticipated administrative support by limited Sutter-Yuba Behavioral Health staff.

Year one of the iCARE Project includes the purchase of five mobile care vans with conversion packages for a total approximate cost of $260,600. These vans will be used to go into the community to make the outreach and engagement connections with the consumers and potential consumers. They will be able to be used as mobile offices, a safe place for consumers, and a space to hold supplies and equipment for the outreach teams. $53,450 in other equipment such as laptops, cell phones, wireless printers, and furniture will be purchased in year one to set up the iCARE teams.
A total of $7,800 over the 5-year project is budgeted to purchase polo shirts, sweatshirts, and rain jackets to identify the iCARE team members in certain locations within the community.

AB114: This Innovation plan will use FY 08/09, 09/10, 10/11, 11/12, 12/13, 13/14, and 14/15 funds that were deemed reallocated to Sutter County via AB114. The amount of AB114 funds that will be expended during FY 2019-20 is $875,550. The amount that will be expended during FY 2020-21 is $1,375,800 and the amount that will be expended during FY 2021-22 is $577,338.

Other funding: MHSA PEI Funding is also being budgeted at $710,600 over the 5-year plan to be spent on LEAP, COACH, and Community-based Trainings.

Amount Subject to Reversion - Description		**Spent FY19-20**	**Spent FY20-21**	**Spent FY21-22**
Innovation Funds -MHSA (to be spent by 6/30/2020)	$1,575,878	875,550	700,328	
Innovation Funds -MHSA (to be spent by 6/30/2022)	$799,815		675,472	124,343
Innovation Funds -MHSA (to be spent by 6/30/2023)	$452,995			452,995
Yearly INN Allocation	$2,400,000			
PEI Funding	$710,600			
Total INN Funding Available	**$5,939,288**			

Federal Financial Participation (FFP) – Non-MHSA Funding: The iCARE Budget does not include any FFP Funding due to the unknown nature of what Medi-Cal billable activities the iCARE team will be performing. After the first two years this will be re-evaluated and if Medi-Cal billable services are being performed the budget will be amended to include such billable services.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1	Salaries						
2	Direct Costs						
3	Indirect Costs	40,000	40,000	20,000	20,000	7,000	$ 127,000
4	Total Personnel Costs	$ 40,000	$ 40,000	$ 20,000	$ 20,000	$ 7,000	$ 127,000
OPERATING COSTS		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
5	Direct Costs	59,200	149,200	149,200	77,700	44,538	$ 479,838
6	Indirect Costs	$60,000	$60,000	$60,000	$60,000	$60,000	$ 300,000
7	Total Operating Costs	$ 119,200	$ 209,200	$ 209,200	$ 137,700	$ 104,538	$ 779,838
NON-RECURRING COSTS (equipment, technology)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
8	Vehicles	260,600					$ 260,600
9	Other Equipment	53,450					$ 53,450
10	Total Non-Recurring Costs	$ 314,050	$ -	$ -	$ -	$ -	$ 314,050
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
11	Direct Costs	300,000	1,025,000	1,025,000	875,000	275,000	$ 3,500,000
12	Indirect Costs	510,600	200,000	175,000	175,000	150,000	$ 1,210,600
13	Total Consultant Costs	$ 810,600	$ 1,225,000	$ 1,200,000	$ 1,050,000	$ 425,000	$ 4,710,600
OTHER EXPENDITURES (please explain in budget narrative)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
14	Clothing	2,300	1,600	2,300	1,600	-	$ 7,800
15							
16	Total Other Expenditures	$ 2,300	$ 1,600	$ 2,300	$ 1,600	$ -	$ 7,800
BUDGET TOTALS							
Personenel (line 1)		$ -	$ -	$ -	$ -	$ -	$ -
Direct Costs (add lines 2, 5, and 11 from above)		$ 359,200	$ 1,174,200	$ 1,174,200	$ 952,700	$ 319,538	$ 3,979,838
Indirect Costs (add lines 3, 6 and 12 from above)		$ 610,600	$ 300,000	$ 255,000	$ 255,000	$ 217,000	$ 1,637,600
Non recurring costs (line 10)		$ 314,050	$ -	$ -	$ -	$ -	$ 314,050
Other Expenditures (line 16)		$ 2,300	$ 1,600	$ 2,300	$ 1,600	$ -	$ 7,800
TOTAL INNOVATION BUDGET		$ 1,286,150	$ 1,475,800	$ 1,431,500	$ 1,209,300	$ 536,538	$ 5,939,288

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR							
ADMINISTRATION:							
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MHSA Funds	40,000	40,000	20,000	20,000	7,000	127,000
2.	Federal Financial Participation						-
3.	1991 Realignment						-
4.	Behavioral Health Subaccount						-
5.	Other funding*(PEI)						-
6.	Total Proposed Administration	40,000	40,000	20,000	20,000	7,000	127,000
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MHSA Funds	100,000	100,000	100,000	100,000	100,000	500,000
2.	Federal Financial Participation						-
3.	1991 Realignment						-
4.	Behavioral Health Subaccount						-
5.	Other funding*(PEI)						-
6.	Total Proposed Evaluation	100,000	100,000	100,000	100,000	100,000	500,000
TOTAL:							
C.	Estimated total mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MHSA Funds	875,550	1,375,800	1,356,500	1,134,300	486,538	5,228,688
2.	Federal Financial Participation						-
3.	1991 Realignment						-
4.	Behavioral Health Subaccount						-
5.	Other funding*(PEI)	410,600	100,000	75,000	75,000	50,000	710,600
6.	Total Proposed Expenditures	1,286,150	1,475,800	1,431,500	1,209,300	536,538	5,939,288

Reedy, Grace@MHSOAC

From: Julia Robinson Shimizu <juliarobinsonshimizu@gmail.com>
Sent: Monday, July 29, 2019 11:42 AM
To: Reedy, Grace@MHSOAC
Subject: Yes please!

Re MH request for comment
YES please!!!
My loved one would have benefitted greatly from
working with individuals not ready or able to engage with available outpatient treatment while concurrently working to strengthen individual and community support systems....the iCARE Team respondto individuals in a non-clinical, mobile, field-based approach prior to and after hospitalization, in consumer homes, homeless encampments, emergency rooms, with law enforcement or...
Oh this would have been wonderful
This would probably helped to avoid countless 5150s and could have helped our family feel less alone and more safe and supported as we tried to navigate crisis services for our loved one

Reedy, Grace@MHSOAC

From:	Lori Litel <LLitel@unitedparents.org>
Sent:	Tuesday, July 30, 2019 2:00 PM
To:	Reedy, Grace@MHSOAC
Cc:	Robancho, Lester@MHSOAC
Subject:	iCARE Innovation Plan Sutter/Yuba Counties

Dear Grace,

United Parents supports the iCARE Innovation Plan of Sutter/Yuba Counties. . Sutter/Yuba relied heavily on consumer and family member input to choose this particular model of care. The plan uses peer advocates for engagement to compliment the iCARE team and uses developed models of peer engagement (Listen Empathize Agree Partner (LEAP) developed by Dr. Xavior Amador and the COACH model developed by the Camden Coalition of Healthcare Providers in Camden, New Jersey. They will also work with family members to offer coping skills training, education and access to services. Family members can also make referrals to the iCARE team. This iCARE Innovation Plan will also offer stigma reduction community education based on consumer/family member feedback. We like the level of stakeholder engagement.

Best regards,

Lori Litel
Executive Director
United Parents
391 S. Dawson Drive, 1A
Camarillo, CA 93012
805 384 1555/1080 Fax
llitel@unitedparents.org

Visit United Parents on Facebook
Visit Parents and Caregivers for Wellness on Facebook
Be sure to "like" us so you can get helpful parenting tools.

The contents of this electronic message is privileged and confidential. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the content of this information is strictly prohibited. If you have received this copy in error, please immediately notify me by phone or e-mail and delete this email and the information therein from your system. (W&I Code, Section 5328, 45 CFR 160 & 164) Thank you.

AGENDA ITEM 4

Action

September 26, 2019 Commission Meeting

Glenn County SMART Project

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will hear a presentation on Glenn County's SMART (System-wide Mental Health Assessment and Response Treatment Team) Innovation project, which was approved by the Commission on August 28, 2014. Additionally, the Commission may consider one or more motions relating to opportunities to explore collaborative partnerships to expand this model.

The System-wide Mental Health Assessment and Response Treatment Team (SMART) is a collaborative multi-agency team that responds quickly and efficiently to critical school incidents such as school threats, suicidal behavior, violence, and bullying. Adapting principles from Los Angeles County's School Threat Assessment Team (START) for use in a very small county, SMART uses proven practices to address school threats and suicidal behavior; prevent bullying; and provides ongoing services to resolve identified issues. The SMART team includes Mental Health staff, law enforcement, probation, and school designees. Each school is in the process of developing school response teams. These teams include school counselors, school psychologist, principals, vice principals, and other key staff. Services offer a wide array of prevention activities and support, crisis response, community threat response, screening, assessment, early identification of school violence, case management monitoring and clinical services.

Enclosure (2): (1) Biographies of County Presenters; (2) PowerPoint Presentation

Glenn County

SMART Team Bios

Detective Greg Felton and Lisa Cull, LMFT

Detective Greg Felton has been employed by the Glenn County Sheriff's Office for approximately 22 years and assigned to the Major Crimes Unit since 2005. Currently, Detective Felton serves as the Major Crimes Unit supervisor as well as the Narcotics Unit supervisor. Detective Felton has been an integral member of the SMART (System Wide Mental Health Assessment and Response Treatment) team since its inception and was actively involved in planning and implementing all components of the program. Detective Felton's leadership, commitment, and integrity have been key to the success of SMART. In 2016, Detective Felton received the United States of America Attorney General's award for Distinguished Service in the Community for his exemplary work in Glenn County.

Lisa Cull is a licensed marriage and family therapist and has been employed by Glenn County Health and Human Services for over 7 years. She has served as the Senior Program Coordinator for the SMART (System Wide Mental Health Assessment and Response Treatment) team for over 4 years. Prior to working in Glenn County, Lisa provided mental health services to students on school campuses, and also worked at an adult inpatient psychiatric facility. Lisa's current specialties are working with youth and families of youth who are involved with the juvenile justice system and youth who have been identified with emotional disturbance by the special education system.

To help develop the SMART team, Lisa Cull and Detective Greg Felton attended a training in Los Angeles County to learn from the START (School Threat Assessment Response Team) about how Glenn County could adopt and develop a similar model of school threat assessment that would serve a small, rural community. They worked closely with Dr. Tony Beliz prior to his retirement from Los Angeles County to learn more about threat assessment and violence prevention within the school system. In 2018, Lisa and Detective Felton attended Gavin DeBecker's Advanced Threat Assessment Academy to gain more knowledge and experience in conducting a threat assessment and preventing targeted acts of violence. This training was conducted by numerous experts in the field from various disciplines.

Amy Lindsey, LMFT

Amy Lindsey, LMFT, is the Behavioral Health Deputy Director and has been employed by Glenn County since 1996. Her vision to create a multidisciplinary team to enhance collaboration and coordination of services to improve lives has been the foundation of the SMART (System Wide Mental Health Assessment and Response Treatment) team. Mrs. Lindsey provides exceptional leadership to the Behavioral Health System of Care, and works continuously to promote health, wellness, and recovery for all county residents.

Nancy Callahan, Ph.D.

Nancy M. Callahan, Ph.D., is the owner of I.D.E.A. Consulting, a consulting company based in Davis, California. Over the past 29 years, she has provided exemplary consultation services to state and county Behavioral Health, Human Service, and Probation agencies. This includes working with counties to facilitate stakeholder groups, write MHSA Plans, design and evaluate PEI programs, and help plan, design, implement, and evaluate Innovation Plans. I.D.E.A. Consulting also supports counties to design and implement Innovative programs by writing and evaluating state and federal grants including Whole Person Care, Safe and Stable Schools, and SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grants. In addition, Dr. Callahan's organization also supports counties in designing and implementing the delivery of culturally responsive services and writing Cultural Competency Plans.

Collaborative Multi-Agency SMART Team: System-Wide Mental Health Assessment Response Treatment

Presentation to the Mental Health Services Act Oversight and Accountability Commission

September 26, 2019

Glenn County Behavioral Health
Glenn County Sheriff's Office
Glenn County Office of Education

© Felton/Cull 2019

Collaborative Multi-Agency SMART Team:

System-Wide ***M***ental Health ***A***ssessment ***R***esponse ***T***reatment

Health & Human Services Agency

Amy Lindsey, LMFT
Behavioral Health Director

Ellen Prose, ASW
Behavioral Health Program Manager

Lisa Cull, LMFT
Behavioral Health Program Coordinator

Janet Mendez, ASW
Behavioral Health Clinician

Calley Pfyl
Behavioral Health Case Manager

Brittny Troughton
Behavioral Health Case Manager

Priscilla Cortes
Behavioral Health Case Manager

Glenn County Sheriff's Office

Richard L. Warren Jr.
Sheriff/Coroner

Greg Felton
Sheriff's Detective

Glenn County Office of Education

Tracey Quarne
GCOE Superintendent

History of the Glenn County SMART Team

- **The Idea:**
  Amy Lindsey, Director, Behavioral Health
  Richard L. Warren, Jr. Glenn County Sheriff
  Tracey Quarne, GCOE Superintendent
  Scott Gruendl, Director of HHSA
- **Modeled after:**
  LA County START (**S**chool **T**hreat **A**ssessment & **R**esponse **T**eam) Program
- **Glenn County Team Visited LA County START Program:**
  - Trained with Dr. Tony Beliz
  - Shadowed START Crisis Reponse
  - Met with mental health and LAPD/ San Bernardino Police Department

What is SMART……..

A collaborative multi-agency team that responds quickly and efficiently to critical incidents that include:

- ➢School Threats of Targeted Violence
- ➢Incidents Warranting Concern of Future Violence
- ➢Crisis Management Support and Consultation

SMART uses proven practices to address school threats; violence prevention; and provide ongoing services to resolve identified issues.

SMART also provides post-incident debriefings

Play Video

Comprehensive School Threat Assessment Guidelines:

Intervention and Support to Prevent Violence

Dewey Cornell

What is a threat?

- Expression of intent to harm someone
- May be spoken, written, or expressed in some other way
- Can be direct or indirect
- Illegal possession of weapons should be presumed to indicate a threat unless investigation reveals otherwise

School Threat Assessment Decision Tree

Step 1. Evaluate the threat.
Obtain a detailed account of the threat, usually by interviewing the person who made the threat, the intended victim, and other witnesses. Write the exact content of the threat and key observations by each party. Consider the circumstances in which the threat was made and the student's intentions. Is there communication of intent to harm someone or behavior suggesting intent to harm?

- No → Not a threat. Might be an expression of anger that merits attention.
- Yes ↓

Step 2. Attempt to resolve the threat as transient.
Is the threat an expression of humor, rhetoric, anger, or frustration that can be easily resolved so that there is no intent to harm? Does the person retract the threat or offer an explanation and/or apology that indicates no future intent to harm anyone?

- Yes → Case resolved as transient; add services as needed.
- No ↓

Step 3. Respond to a substantive threat.
For all substantive threats:

a. Take precautions to protect potential victims.
b. Warn intended victim and parents.
c. Look for ways to resolve conflict.
d. Discipline student, when appropriate.

Serious means a threat to hit, fight, or beat up whereas very serious means a threat to kill, rape, or cause very serious injury with a weapon.

- Serious → Case resolved as serious substantive threat; add services as needed.
- Very Serious ↓

Step 4. Conduct a safety evaluation for a very serious substantive threat.
In addition to a-d above,

e. Screen student for mental health services and counseling; refer as needed.
f. Law enforcement investigation for evidence of planning and preparation, criminal activity.
g. Develop safety plan that reduces risk and addresses student needs. Plan should include review of Individual Educational Plan if already receiving special education services and further assessment if possible disability.

↓

Step 5. Implement and monitor the safety plan.
Document the plan.
Maintain contact with the student.
Monitor whether plan is working and revise as needed.

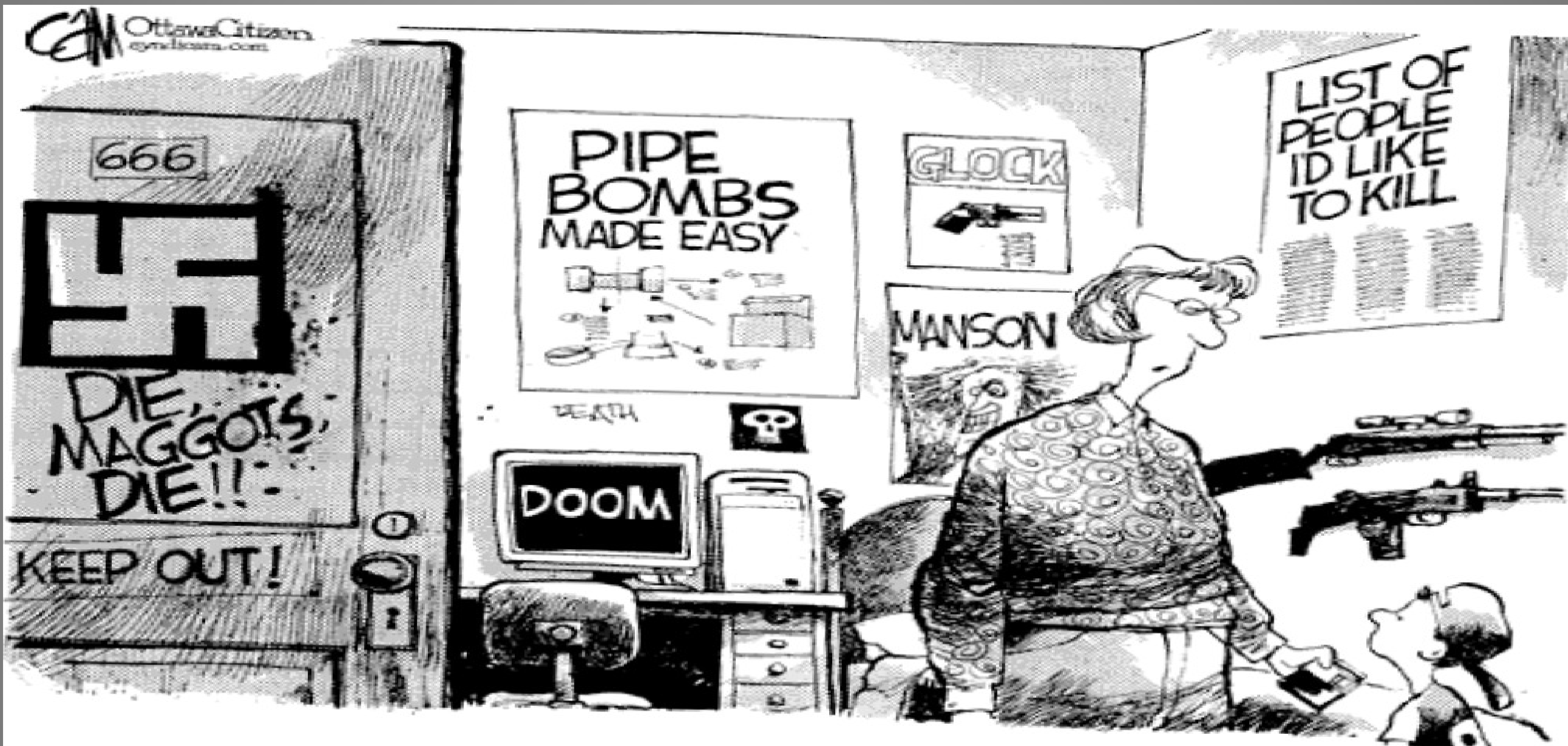
6 Principles of threat assessment

U.S. Secret Service and Department of Education

- Prevention is possible.
- Consider the context.
- Adopt an investigative mindset.
- Rely on facts, not profiles.
- Gather information from multiple resources.
- Does the student pose a threat?

Continuum of Threats

Warning of Impending violence	Substantive
Attempts to Intimidate or frighten	Possibly Substantive
Thrill of causing a disruption	
Attention-seeking, boasting	
Fleeting expression of anger	Transient
Joke	
Figure of speech	



"I found CIGARETTES in YOUR room"

School Site Teams

- School teams make it easier for the assessment of student threats to be a part of the regular school routine
- Threat assessment requires careful consideration of the environmental context: staff are more familiar with students and personnel
- External teams may not agree with the seriousness of the threat or vice versa
- School site team should include:
  - Administrator
  - School Psychologist
  - School Counselor
  - Law Enforcement

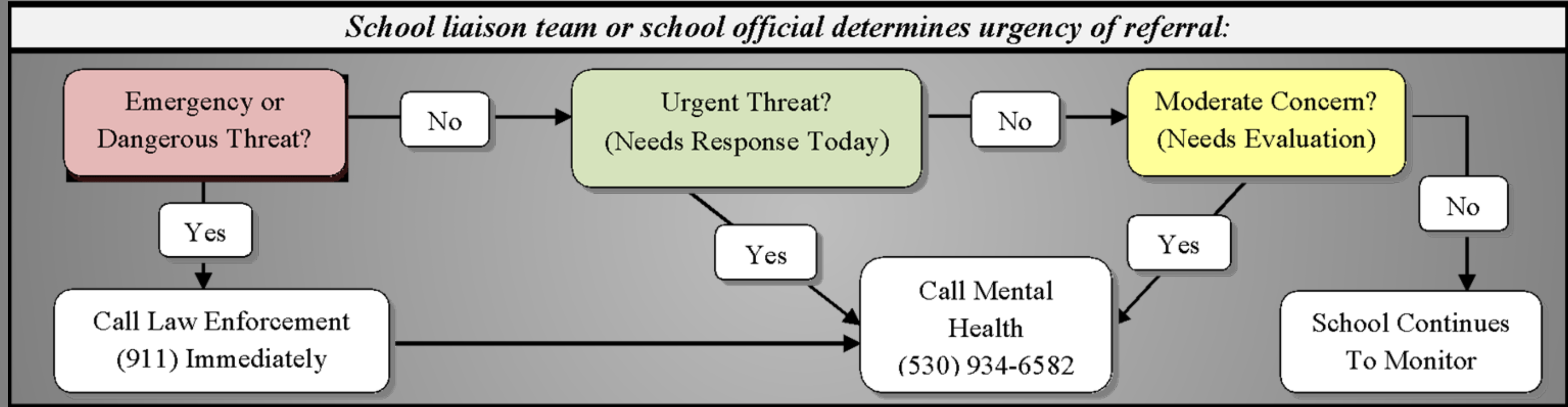
Transient Threat Examples

- "I am going to kill you" – said as a joke
- "I'll get you next time" – said after a fight but retracted after the two students reconcile
- A student is found with a pocket knife that he accidentally left in his backpack
- "I oughta shoot that teacher" – said in anger but retracted after the student calms down
- "I'm gonna bust you up" – said in anger but retracted after the student calms down

Substantiated Threat Examples

- A student tells a classmate that he has prepared a hit list of people whom he intends to shoot on the following Monday
- A student tells a classmate, "I'm gonna strangle him until he's dead."
- A student says that he is tired of being bullied at school and is going to bring a gun to defend himself

Referral Process to SMART Team



Trends Over the Last 5 Years

What we have learned……

- Increase in social media postings regarding suicide.
- Increase in reported self-harm on school campuses.
- Increase in number of calls for crisis response to assess for suicidal ideation.
- Increased feelings of helplessness, fear, and anxiety for adults involved in youth’s lives (teachers, parents, coaches, etc.).
- Younger population of students making threats of self-harm and threats to harm others.

Glenn County Crisis Response

- All crisis calls directed through 24-hour crisis line **(1-800-507-3530)**
- Day Crisis worker will triage all crisis calls
- Day Crisis worker will link to SMART staff as appropriate
- How to access crisis services after hours

Case Study….

- Detective Felton was contacted by a local vice-principal regarding a students writing assignment.

Student Na

Weekly Work Log

COPY

Week No. 7

In this area write down what you accomplished today. No credit for "WORK ON PROJECT "IN THIS AREA.

Daily Plan Sample: Used Scroll Saw to cut out push stick outline.

Monday

DAILY PLAN: Monday

today I failed misetably because I already messed up and I hate Woodshop Black people don't do this

? Watch what you write.

DAILY PLAN: Tuesday

today I'm still gonna fail woodshop. But then I decided to restart and try. Better attitude.

DAILY PLAN: Wednesday

Today I restarted on my bird house and got two pieces and hopefully get done or at least glue it together.

DAILY PLAN: Thursday

Nevermind I hate this fucking class it sucks wood is not important I wanted Auto but instead I got put into this shithole I'm going to kill myself or shoot up the school fuck life.

DAILY PLAN: Friday

this class is boring and I want to die and I hate everyone I want to switch out of this shithole

I Quit

DAILY PLAN: Thursday

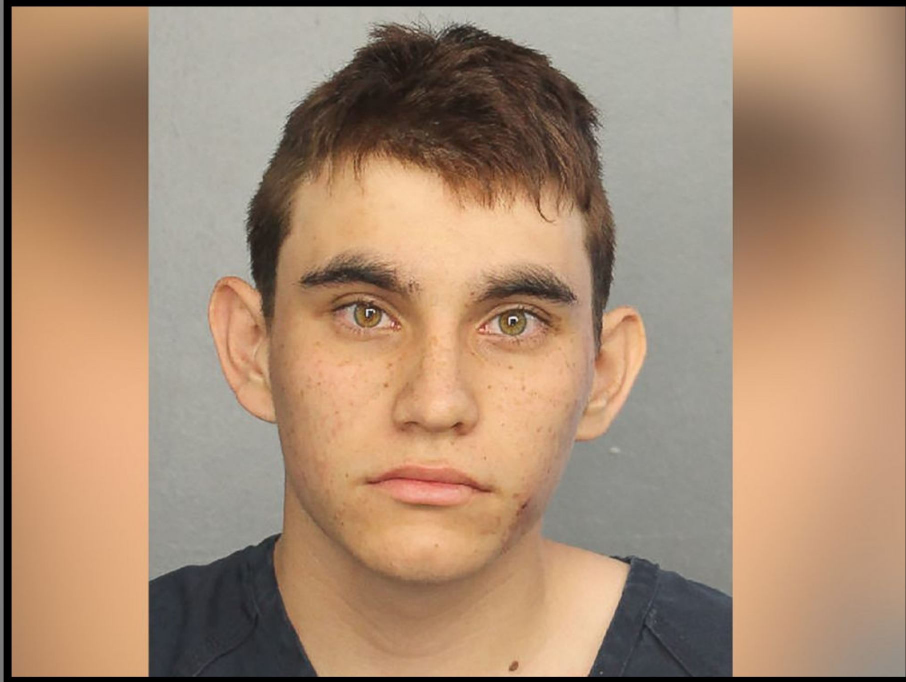
Nevermind I hate this fucking class it sucks wood is not important I wanted Auto but instead I got put into this shithole Im going to kill myself or shoot up the school fuck life.

Case Study….

- Detective Felton was contacted by The Bureau of Alcohol, Tobacco, Firearms and Explosives regarding a student’s social media postings.

CASE# GCSO2018005179

Warning Signs- Parkland, FL.



- Broken attachments in childhood
- 2013- LE contact due to throwing mother against wall
- 2014- used BB gun to shoot chicken
- 2016- Instagram post about “planned to shoot up the school”(confirmed that he owned knives and BB gun)
- Adoptive mother had died
- Had been diagnosed with depression and engaged in self-harm
- Expelled from school for “behavioral issues”
- Leakage (several tips to FBI)

MOSAIC and School Threat Assessment

The SMART team utilizes MOSAIC to assess the level of threat for each referral. The team also utilizes a mini school threat assessment for immediate evaluation and crisis intervention.

The MOSAIC is a systematic method, using a standardized series of questions, to assess the level of threat. The SMART team interviews and evaluates statements from various people in the students life, such as:

• Youth	• School Personnel
• Teacher(s)	• Parent/Caregiver(s)
• Other student(s)	• Others

SMART Team Meetings

SMART team meets weekly to review:

- New referrals
- Active cases
- Coordination of care
- Appropriate aftercare

SMART Multi-Disciplinary Team (MDT) meets monthly to discuss school threat assessments, other agency involvement (Child Welfare Services, Probation, Law Enforcement), and develops strategies for next steps.

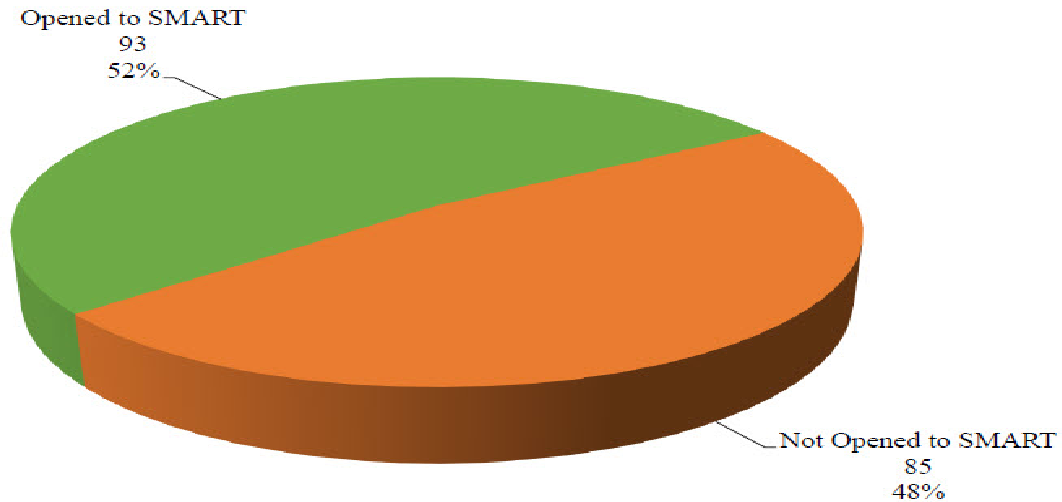
Ongoing Services

SMART team will deliver mental health services, as needed, to **youth**, and coordinate with the **teacher**, and/or **family member**, to resolve critical incidents and to address any ongoing needs.

Students needing ongoing support will be linked to **mental health and community or adjunctive resources** to ensure the incident is fully resolved.

Glenn County Mental Health Services
SMART Team
January 2015 - June 2019

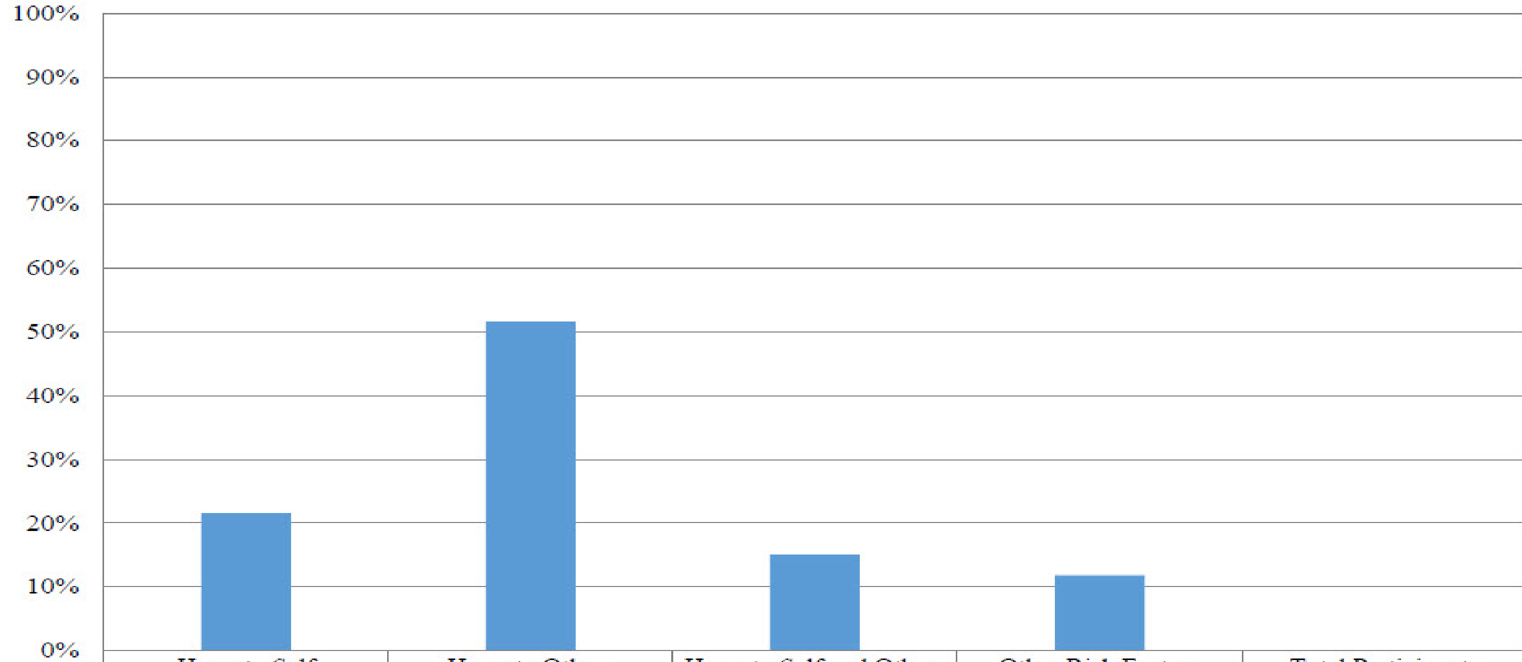
Total Youth Referred to SMART*
(N=178)



*Some youth may have multiple referrals to SMART.

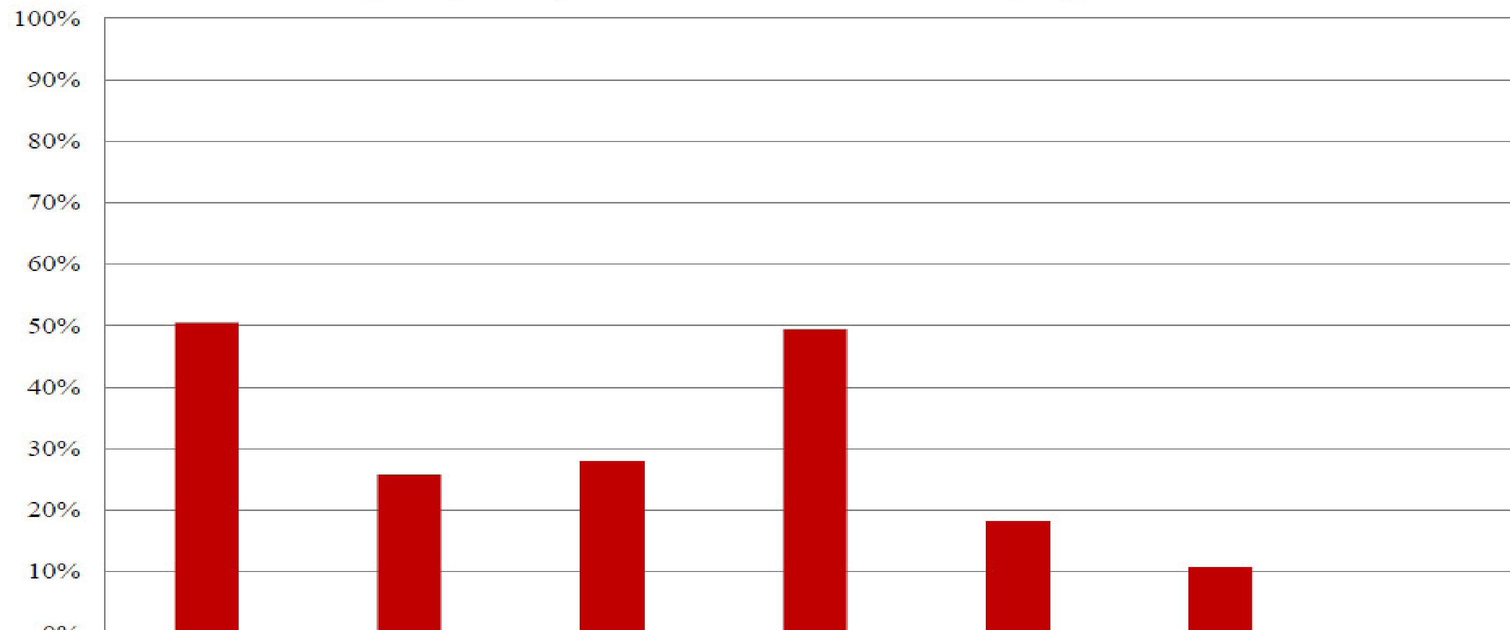
Glenn County Mental Health Services
SMART Team
Reason for Referral for Youth Opened to SMART
(Harm to Self, Others, or Other Risk Factors)

January 2015 - June 2019



	Harm to Self	Harm to Others	Harm to Self and Others	Other Risk Factors	Total Participants
# Participants	20	48	14	11	93
% Participants	21.5%	51.6%	15.1%	11.8%	100.0%

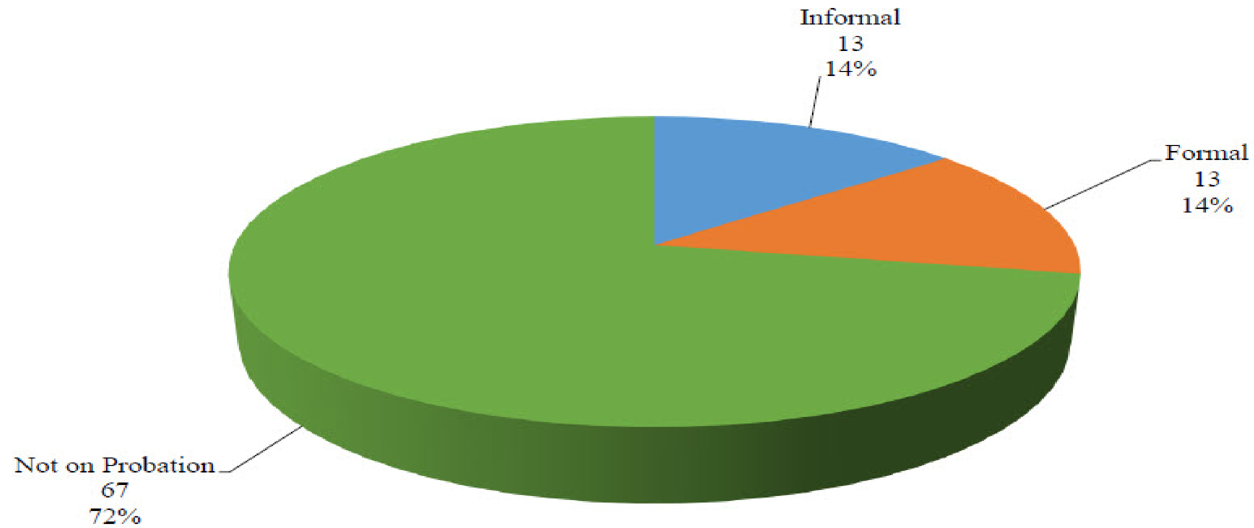
Glenn County Mental Health Services
SMART Team
SMART Youth and Involvement with Other Agencies
January 2015 - June 2019
(Participants may have involvement in more than one agency)



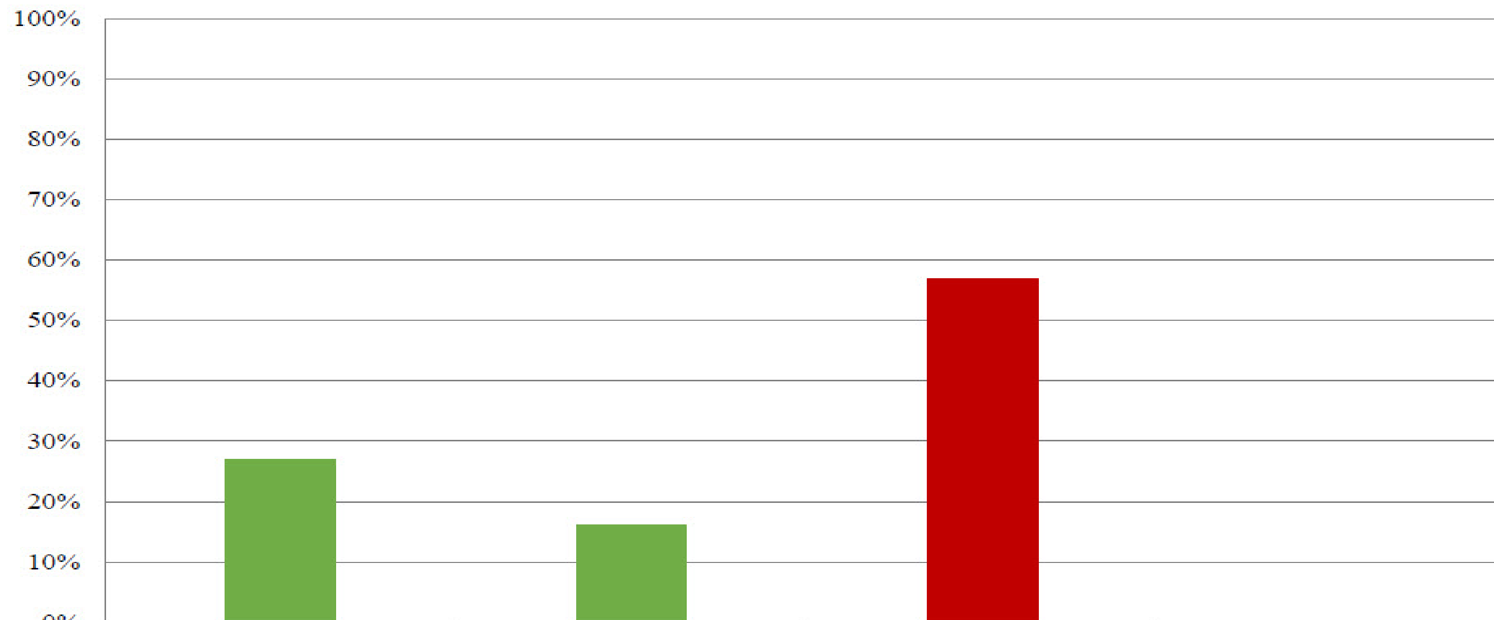
	School Suspensions	Substance Use Treatment	Probation	CWS	Arrest/Juvenile Detention	Inpatient Hospitalization	Total Participants
# Participants	47	24	26	46	17	10	93
% Participants	50.5%	25.8%	28.0%	49.5%	18.3%	10.8%	100.0%

Glenn County Mental Health Services
SMART Team
January 2015 - June 2019

Probation Status for Youth Opened to SMART
(N=93)

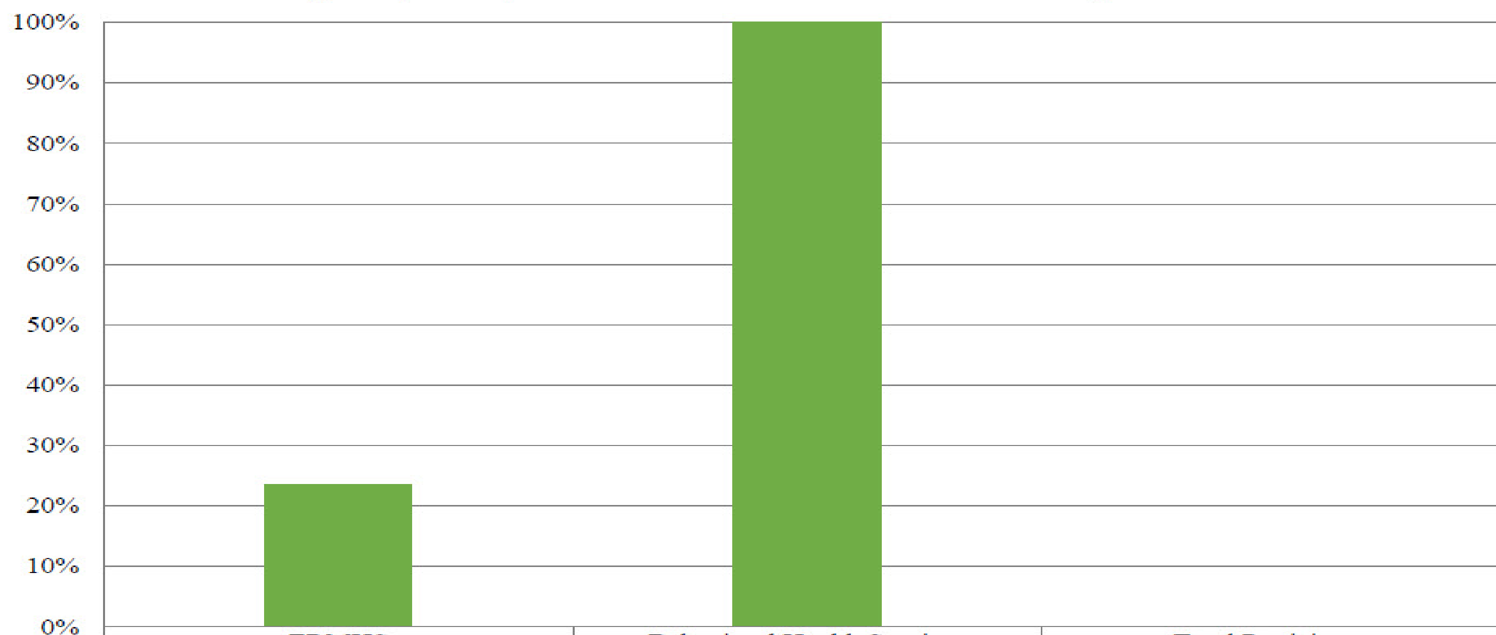


Glenn County Mental Health Services
SMART Team
Number and Percent of Participants by School IEP
for Youth Opened to SMART
January 2015 - June 2019



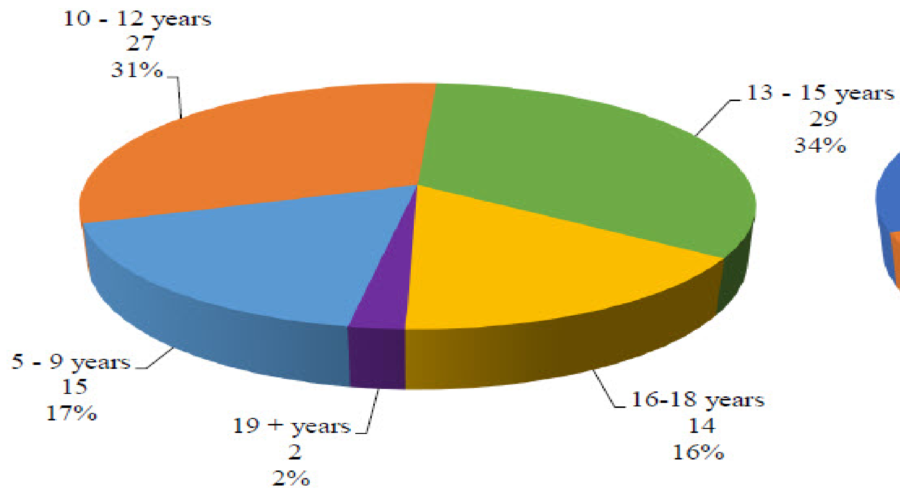
	Existing IEP	New IEP after SMART Involvement	No IEP	Total Participants
# Participants	25	15	53	93
% Participants	26.9%	16.1%	57.0%	100.0%

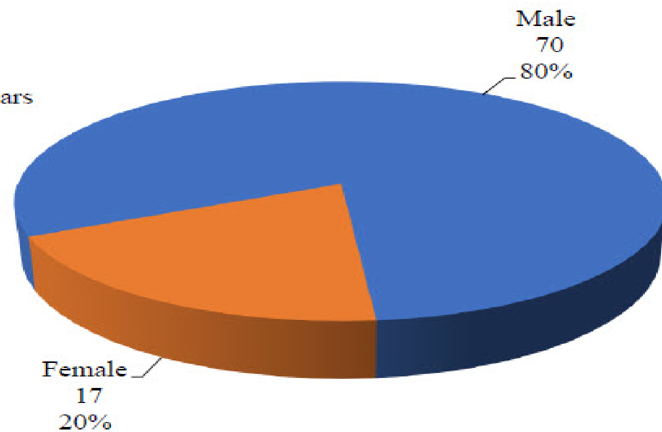
Glenn County Mental Health Services
SMART Team
Number and Percent of Participants by Mental Health Services
for Youth Opened to SMART
January 2015 - June 2019
(Participants may receive ERMHS and Behavioral Health Services.)



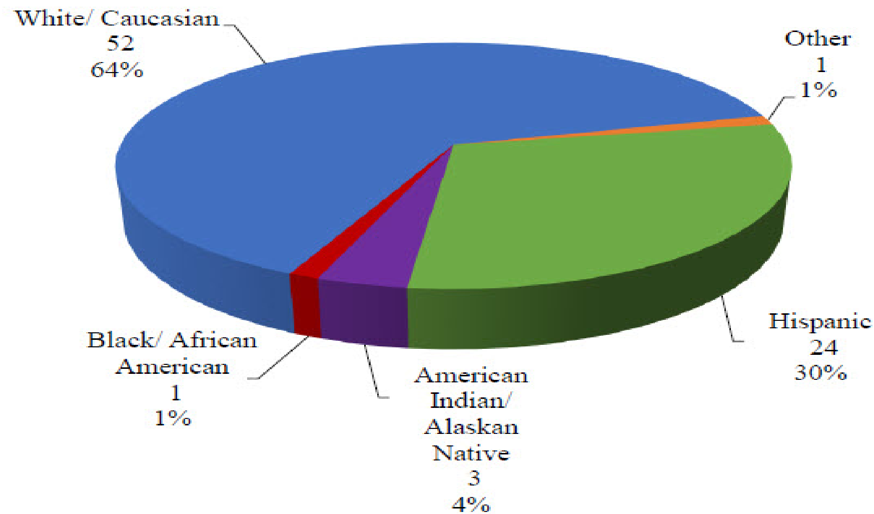
	ERMHS	Behavioral Health Services	Total Participants
# Participants	22	93	93
% Participants	23.7%	100.0%	100.0%

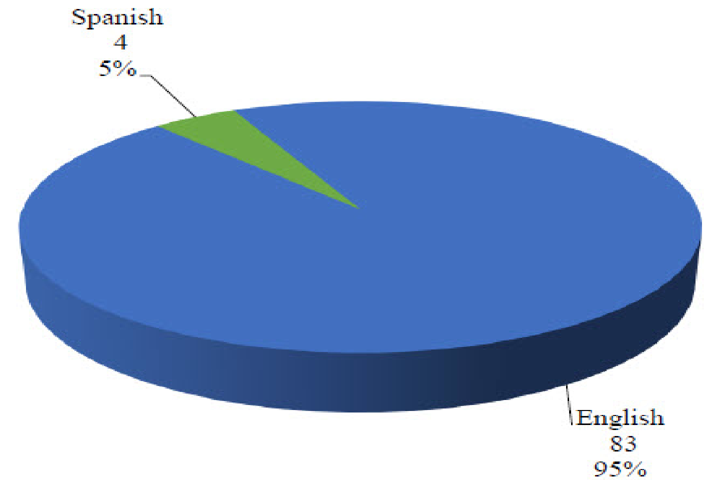
Glenn County Mental Health Services
SMART Team
January 2015 - June 2019



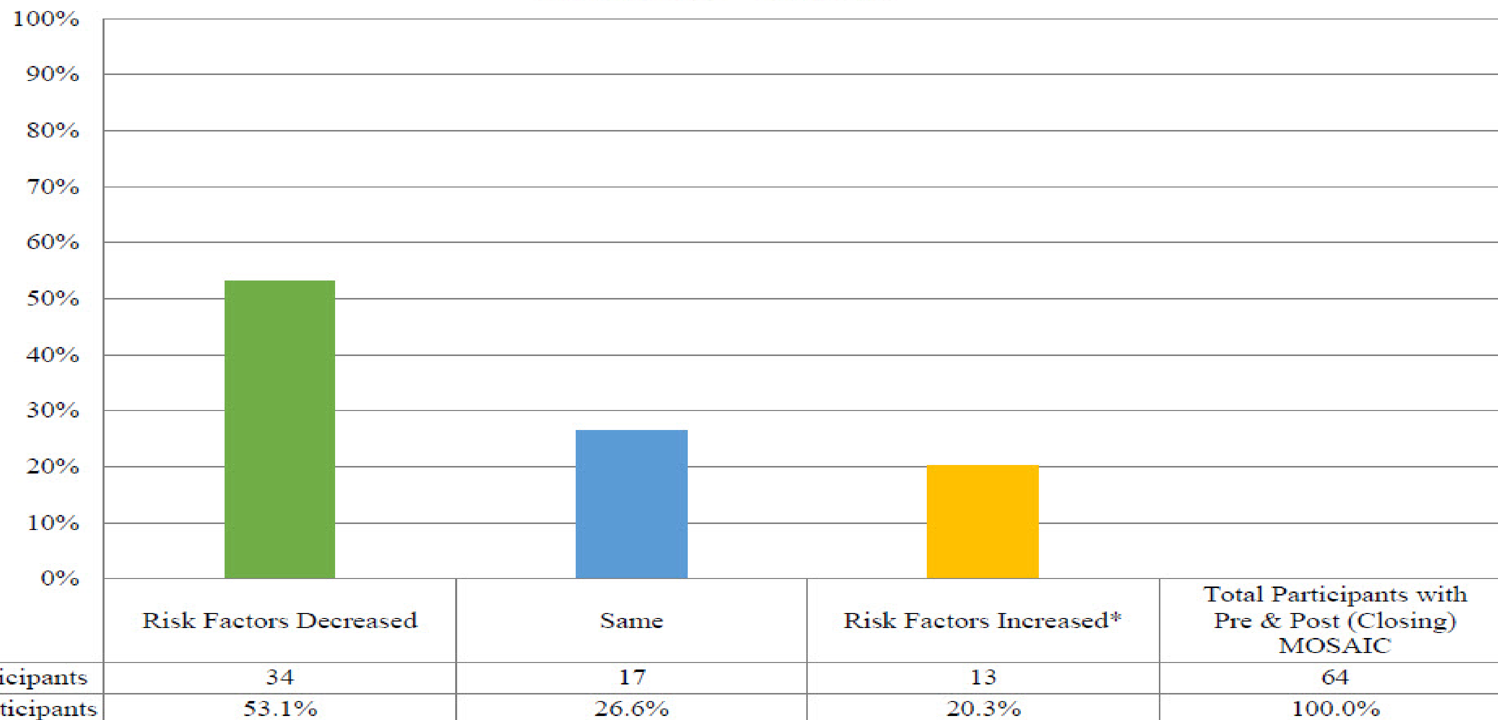


Glenn County Mental Health Services
SMART Team
January 2015 - June 2019





Glenn County Mental Health Services
SMART Team
Number and Percent of Participants by <u>MOSAIC Risk Factors</u>
January 2015 - June 2019

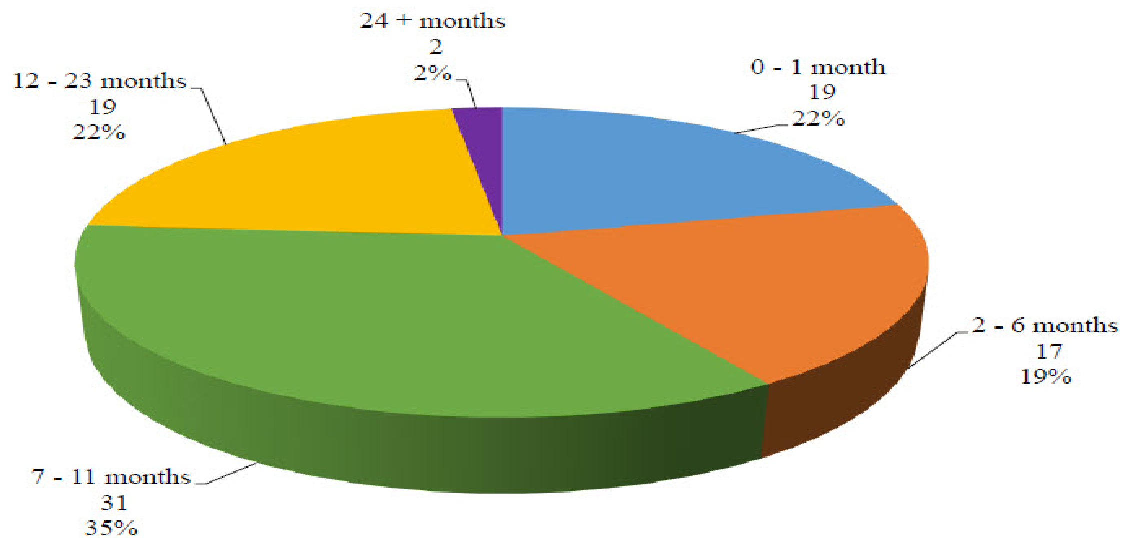


	Risk Factors Decreased	Same	Risk Factors Increased*	Total Participants with Pre & Post (Closing) MOSAIC
# Participants	34	17	13	64
% Participants	53.1%	26.6%	20.3%	100.0%

*Some participants are discharged to higher levels of care or move out of the county.

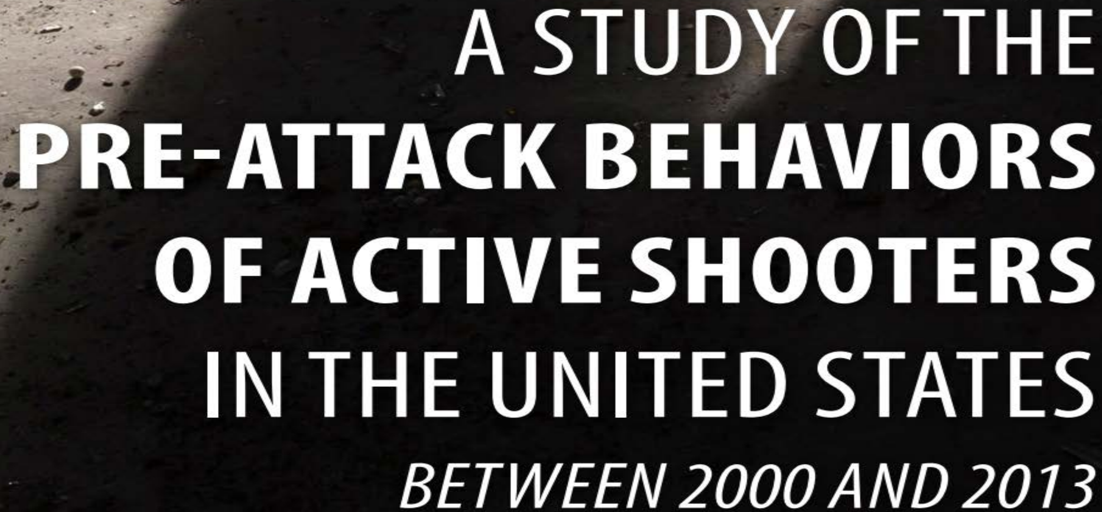
Glenn County Mental Health Services
SMART Team
January 2015 - June 2019

Length of Service in SMART *
(N=88)



*Some participants may have multiple admissions to SMART.

In June 2018, the FBI Releases an important study…



Premise of the study

- In 2017, there were 30 active shootings in the United States (largest ever recorded by the FBI during a 1 year period)
- In the weeks and months before an attack, most active shooters engaged in signal behaviors
- FBI's objective was to examine specific behaviors that may precede an attack (hopefully to prevent future violence)

Key Findings

- 63 active shooters examined did not appear to be uniform in any way (no specific profile)
- 77% of subjects spent a week or longer planning the act of violence
- Majority of active shooters acquired the gun legally
- FBI could only verify that 25% of shooters had ever been diagnosed with a mental illness (only 3 diagnosed with psychotic disorder)

Key Findings

- On average, each active shooter displayed 4-5 concerning behaviors observable to others (related to mental health, problematic interpersonal issues, leakage of violent intent)
- For active shooters under 18 years, ***school peers*** and ***teachers*** were more likely to observe concerning behaviors than family members

Concerning Behavior	Number	%
Mental health	39	62
Interpersonal interactions	36	57
Leakage	35	56
Quality of thinking or communication	34	54
Work performance*	11	46
School performance**	5	42
Threats/confrontations	22	35
Anger	21	33
Physical aggression	21	33
Risk-taking	13	21
Firearm behavior	13	21
Violent media usage	12	19
Weight/eating	8	13
Drug abuse	8	13
Impulsivity	7	11
Alcohol abuse	6	10
Physical health	6	10
Other (e.g. idolizing criminals)	5	8
Sexual behavior	4	6
Quality of sleep	3	5
Hygiene/appearance	2	3

* Based on the 24 active shooters who were employed at the time of the offense

** Based on the 12 active shooters who were students at the time of the offense

Lastly

- Nearly half of the active shooters had suicidal ideation or engaged in suicide-related behaviors prior to the attack (n= 30; 48%).
- Of the 30 who showed signs of suicidal ideation, 7 made actual suicide attempts (23%).
- Collective and collaborative engagement ***can*** prevent acts of violence (law enforcement, teachers, mental health professionals, family, threat assessment professionals, friends, social workers, school resource officers, etc…).

Attorney General's Award

Questions or Comments?

Contact Information

Glenn County Behavioral Health

Amy Lindsey, Behavioral Health Director- alindsey@countyofglenn.net
Ellen Prose, Behavioral Health Program Manager- eprose@countyofglenn.net
Lisa Cull, SMART Program Coordinator- lcull@countyofglenn.net
Janet Mendez, Behavioral Health Clinician- jmendez@countyofglenn.net
Calley Pfyl, Behavioral Health Case Manager- cpfyl@countyofglenn.net
Brittny Troughton, Behavioral Health Case Manager-**btoughton@countyofglenn.net**
Priscilla Cortes, Behavioral Health Case Manager- pcortes@countyofglenn.net

Glenn County Office Of Education

Tracey Quarne, Superintendent- traceyquarne@glenncoe.org

Glenn County Law Enforcement

Richard L. Warren Jr. Sheriff/Coroner-rwarren@countyofglenn.net
Greg Felton, Glenn County Sheriff's Detective- gfelton@countyofglenn.net

AGENDA ITEM 5

Action

September 26, 2019 Commission Meeting

Election of the Chair and Vice-Chair for 2020

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2020 will be conducted at the October 25, 2018 Commission Meeting. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the Commission. The term is for one year and starts January 2020.

This agenda item will be facilitated by Chief Counsel, Filomena Yeroshek.

Enclosures (1): Commissioner Biographies

Handout: None

Commissioner Biographies
September 2019

Reneeta Anthony, Fresno
Joined the Commission: January 2016
Reneeta Anthony has been executive director at A3 Concepts LLC since 2013. She was principal staff analyst at the Fresno County Department of Social Services from 2005-2012, at the Fresno County Department of Behavioral Health from 2004-2005 and at the Fresno County Human Services System from 2001-2004. Anthony was principal staff analyst at the Fresno County Department of Children and Family Services from 2000-2001, where she was senior staff analyst from 1999-2000. Commissioner Anthony fills the seat of a family member of an adult child with a severe mental illness.

Mayra Alvarez, Los Angeles
Joined the Commission: December 2017
Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization. She served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California Berkeley. Commissioner Alvarez fills the seat of the Attorney General/designee.

Lynne Ashbeck, Clovis
Current MHSOAC Vice Chair
Joined the Commission: February 2016
Lynne Ayers Ashbeck is the senior vice president of community engagement and population wellness for Valley Children's Healthcare. She has also served as vice president at Community Medical Centers; regional vice president at the Hospital Council of Northern and Central California; director of Continuing and Global Education at California State University, Fresno; and director of education at Valley Children's Hospital. She is an elected Councilmember in the City of Clovis, first elected in 2001. She is also a member of the California Partnership for the San Joaquin Valley Board of Director and the Maddy Institute Board of Directors. She received her Master of Arts degree from Fresno Pacific University and a Master of Science degree from California State University, Fresno. Vice Chair Ashbeck fills the seat of a representative of a health care service plan or insurer.

Senator Jim Beall, San Jose
Joined the Commission: February 2015
Jim Beall was elected to the California State Senate in 2012 and represents the 15th Senate District. He was elected to the State Assembly in November 2006, representing District 24. He is the chairman of the Senate Transportation Committee, in addition to serving on several other committees. He has spent three decades in public service as a San Jose City Councilman, a Santa Clara County Supervisor and an Assembly member. On the Commission, Senator Beall represents the member of the Senate selected by the President pro Tempore of the Senate.

Ken Berrick, Oakland
Joined the Commission: December 2018
Ken Berrick has been chief executive officer at Seneca Family of Agencies since 1985 and a trustee for Area 3 of the Alameda County Office of Education since 2008. He is a fellow of the Pahara Institute and a member of the Alliance for Strong Families and Communities, California Child Welfare Council, Alameda County Mental Health Services Act Planning Commission, California Alliance of Child and Family Services and Support, Opportunities and Rapport for Youth. Commissioner Berrick fills the seat of a mental health professional.

John Boyd, Psy.D, Folsom
Joined the Commission: June 2013
John Boyd is Sutter Health's Chief Executive Officer of Mental Health Services. He has an extensive background in healthcare administration and mental health. Prior to joining Sutter in 2008, he served as Assistant Administrator for Kaiser Permanente Sacramento Medical Center and has worked as both an inpatient and outpatient therapist in several organizations. He is a Board Member of National Mental Health America; he has also served in other appointed capacities, including City of Sacramento Planning Commissioner. Boyd is a Fellow with the American College of Healthcare Executives. He earned his doctorate in psychology at California School of Professional Psychology and his MHA from USC. Commissioner Boyd represents an employer with more than 500 employees.

Bill Brown, Lompoc
Joined the Commission: December 2010
Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980. Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy and the Delinquency Control Institute. Commissioner Brown fills the seat of a county sheriff.

Keyondria Bunch, Ph.D., Los Angeles
Joined the Commission: August 2017
Keyondria Bunch, Ph.D., has been a Supervising Psychologist for the Emergency Outreach Bureau School Threat Assessment Response Team at the Los Angeles County Department of Mental Health since 2019, where she has served in several positions since 2008. These include clinical psychologist for the Emergency Outreach Bureau, clinical psychologist for the Specialized Foster Care Van Nuys Co-Located Program, clinical psychologist for juvenile justice mental health quality assurance and a clinical psychologist for Valley Coordinated Children's Services. She was also an adjunct lecturer at Antioch University in 2015. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles
Joined the Commission: February 2018
Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017. Assemblymember Carrillo has advocated for educational opportunity, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of community-based radio program "Knowledge is Power" in Los Angeles. Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived in the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Itai Danovitch, M.D., Los Angeles
Joined the Commission: February 2016
Itai Danovitch has been chair of the Psychiatry Department at Cedars-Sinai Medical Center since 2012, where he has held several positions since 2008, including director of addiction psychiatry clinical services and associate director of the Addiction Psychiatry Fellowship. He is a member of the American Society of Addiction Medicine and the American Psychiatric Association and past president of the California Society of Addiction Medicine. Danovitch earned a Doctor of Medicine degree from the University of California, Los Angeles School of Medicine and a Master of Business Administration degree from the University of California, Los Angeles School of Management. Commissioner Danovitch fills the seat of a physician specializing in alcohol and drug treatment.

David Gordon, Sacramento
Joined the Commission: January 2013
David Gordon has been county superintendent at the Sacramento County Office of Education since 2004. He served at the Elk Grove Unified School District as superintendent from 1995-2004. He worked at the California Department of Education as deputy superintendent from 1985-1991. He earned a Master of Education degree from Harvard University. Commissioner Gordon fills the seat of a superintendent of a school district.

Mara Madrigal-Weiss, San Diego
Joined the Commission: September 2017
Mara Madrigal-Weiss is the Director of Wellness and Student Achievement with the San Diego County Office of Education. Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director. Madrigal-Weiss received her M.A. in Human Behavior from National University; a M.Ed in counseling and a M.Ed in Educational Leadership from Point Loma Nazarene University. She was part of the California Department of Education's Student Mental Health Policy Workgroup that supported the passage of AB 2246 requiring all school districts in California to adopt a suicide prevention policy. Commissioner Madrigal-Weiss fills the seat of designee of the State Superintendent of Public Instruction.

Gladys Mitchell, Sacramento
Joined the Commission: January 2016
Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009. She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993. She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

Khatera Tamplen, Pleasant Hill
Current MHSOAC Chair
Joined the Commission: June 2013
Khatera Aslami Tamplen has been the consumer empowerment manager at Alameda County Behavioral Health Care Services since 2012. She was executive director at Peers Envisioning and Engaging in Recovery Services from 2007-2012 and served in multiple positions at the Telecare Corporation Villa Fairmont Mental Health Rehabilitation Center from 2002-2007, including director of rehabilitation. Tamplen is a member of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services National Advisory Council and a founding member of the California Association of Mental Health Peer Run Organizations. Chair Tamplen represents clients and consumers.

Tina Wooton, Santa Barbara
Joined the Commission: December 2010
Tina Wooton has worked in the mental health system for 25 years, advocating for the employment of consumers and family members at the local, state and federal levels. From 2009 to 2019 she served as the Consumer Empowerment Manager for the Santa Barbara County Department of Alcohol, Drug, and Mental Health Services. From 2005 through 2009 she worked as the Consumer and Family member liaison for the California State Department of Mental Health and was staff to the state Mental Health Services Act Implementation Team. Between 1997 and 2005 she served as Consumer Liaison for the Mental Health Association / County Mental Health of Sacramento and as service coordinator for Human Resources Consultants from 1994 through 1997. Wooton is a volunteer at the Santa Barbara Rape Crisis Center and a Santa Barbara Elks member. Commissioner Wooton represents clients and consumers.

AGENDA ITEM 6

Action

September 26, 2019 Commission Meeting

Draft Strategic Plan

Summary: Applied Survey Research will present the Commission with its 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.

Presenters:
- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig-Niclai, Vice President of Evaluation, Applied Survey Research

Enclosure (3): (1) Commission Update; (2) Draft Results-Based Strategic Plan 2019-2023; and (3) Implementation Plan.

Handouts: None

Results-Based Strategic Plan 2019-2024:

Commission Update

September 26, 2019

Prepared in partnership with Applied Survey Research

Agenda Overview

Where we've been:

- Strategic Planning Purpose and Process

Where we are:

- Results-Based Strategic Plan

Where we're going:

- Implementation Plan

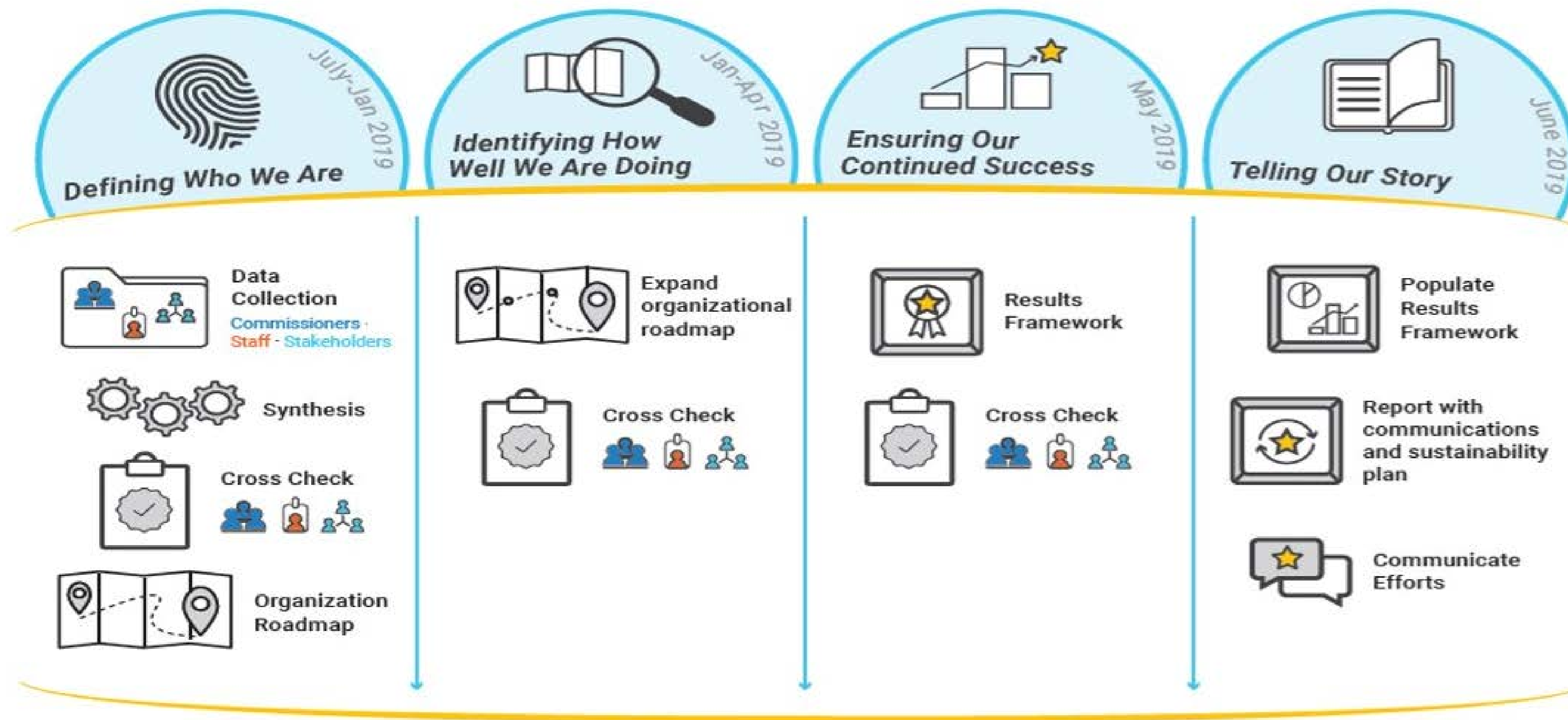
Strategic Planning Goals

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

Strategic Planning Process

Applied Survey Research (ASR) led the Commission through the four phases of this project



Affirming the Commission's Role, Scope and Results

ASR collected data to seek input about the Commission, in terms of:

- Core purpose and role
- Short term desired results
- Longer term desired results
- High value and lower value strategies
- Ways to strengthen the Commission's work

442 respondents were reached through key informant interviews, partner surveys, and staff surveys, reflecting a diverse array of partners in mental health. *

- Commissioner / Emeritus n=14
- Commission Staff n=24
- Community Based Organization n=107
- County Public Agency n=118
- State Public Agency n=39
- Legislator/ Legislative Staff n=6
- Funder/ Grant Maker n=6
- Advocate n=140
- Consumer n=44
- Parent or Family Member n=67

* Multiple response question; respondents could select more than option to describe themselves

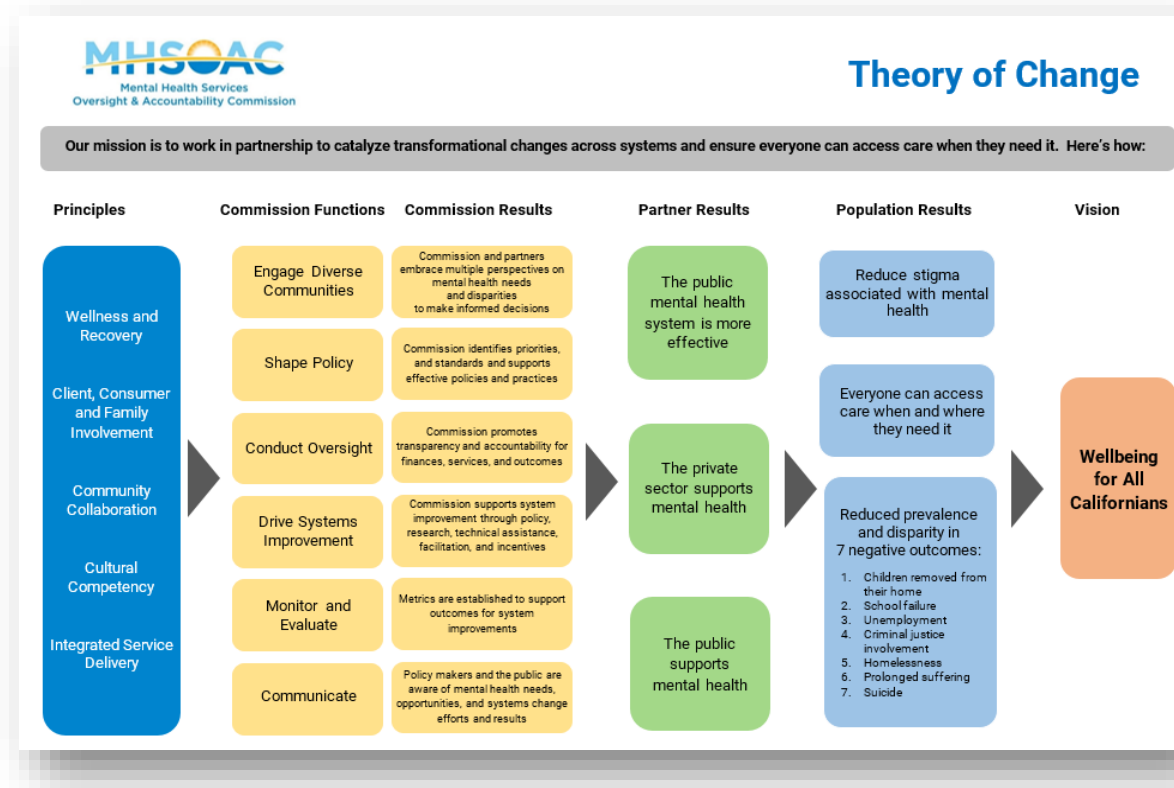
Creating the Commission's Theory of Change

After several months of data collection, cross -checking and reflection, the Commission finalized its Theory of Change. The Theory of Change helps the Commission inform why it does what it does.

A Roadmap to Results

The Theory of Change conveys:

- The direct change or results expected
- The desired results for partners
- How these transformations should bring about better results for California's population as a whole
- The vision that guides the Commission and its partners



Results Framework

The Commission's Theory of Change describes the commitment to principles, the core work, and desired results.

But how does this commitment get measured?

A Results Framework is being developed to measure:

- Commission results
- Partner results
- Population-wide results

Commission Results — Results Framework

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

Cross-Checking for Accuracy

Throughout the planning process, numerous input sessions were held with the Commission and partners to gather feedback and confirm the Commission's priorities.

Date	Action
September 2018 Commission	Round table discussions about the Commission's core purpose
October 2018	Key informant interviews and 400+ surveys about purpose, role, desired results, and valued efforts
November 2018 Commission	Shared findings, discussed broader focus of the Commission, and introduced the Theory of Change
January 2019 All-Staff	Shared updated draft Theory of Change; Solicited input
February 2019 Commission	Reviewed Updated Theory of Change
March 2019	Made further refinements to Theory of Change; drafted Results Framework
April 2019 Design Team	Refined Results Framework
April 2019 Commission	Presented final Theory of Change and progress on creating Results Framework
July 2019 All-Staff	Solicited input about measures for each result; updated Results Framework

Implementing Change

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

Acknowledgements

- The Commission
- Commission Staff

- Participants in key informant interviews, online surveys and cross-checking sessions

Results-Based Strategic Plan 2019-2023

Transforming California's Mental Health Services to Achieve Wellbeing for All

Table of Contents

Strategic Planning Goals

Results-Based Strategic Plan:

- Vision, Mission and Principles
- Theory of Change
- Commission's Core Functions and Results
- Partner Results
- Population Results

Next Steps for Implementation

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

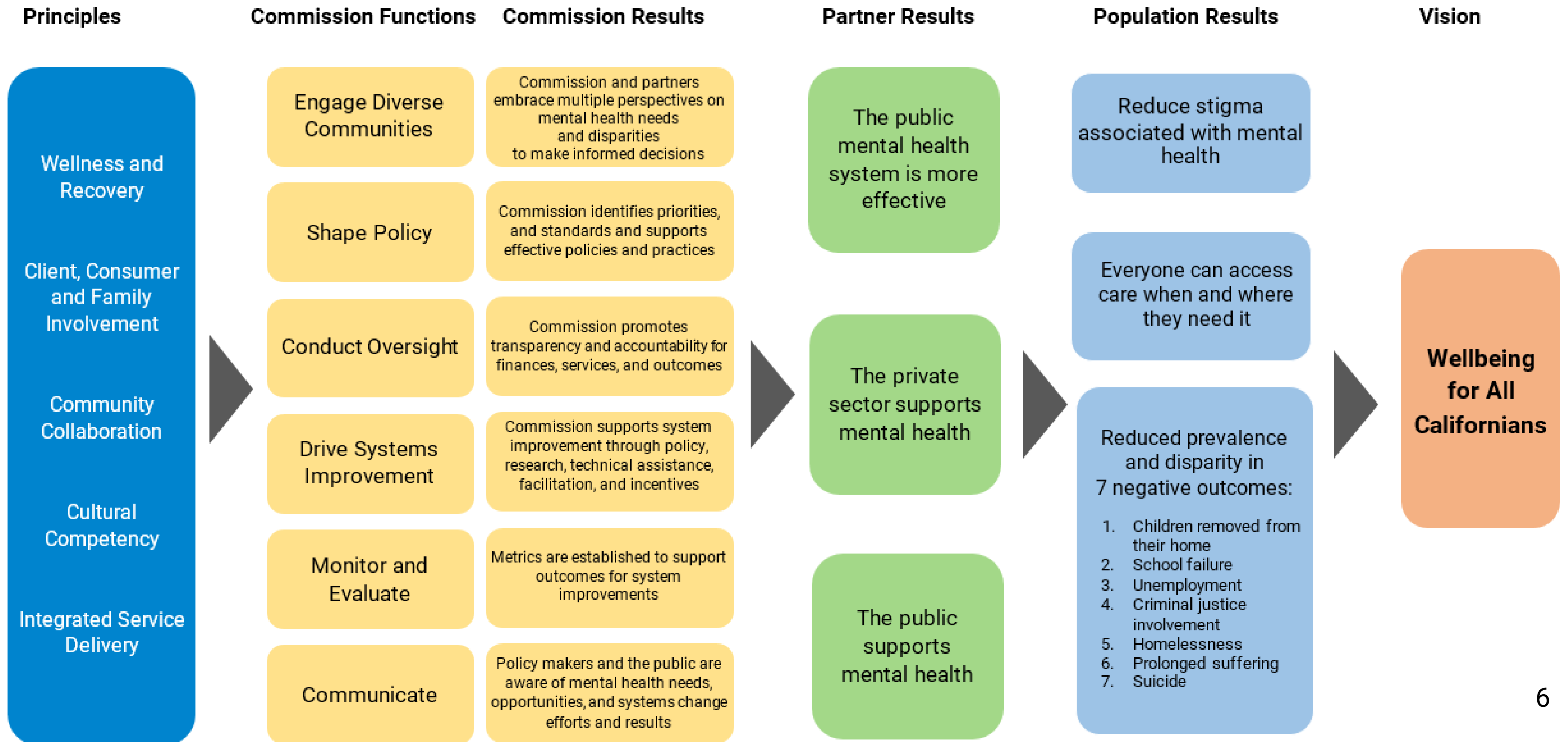
Vision

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))

Core Function	Result
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

Result	Details
The public mental health system is more effective	**The Public Mental Health System:** • Counties will continuously improve access, quality, and outcomes • Scaling up of effective strategies 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:** • Public will to support 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

MHSOAC

Mental Health Services
Oversight & Accountability Commission

Results-based Strategic Plan 2019-2023

Implementation Plan

September 2019

Prepared in partnership with Applied Survey Research

Next Steps for Implementation

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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:

	Step	Description
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.

	Step	Description
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.

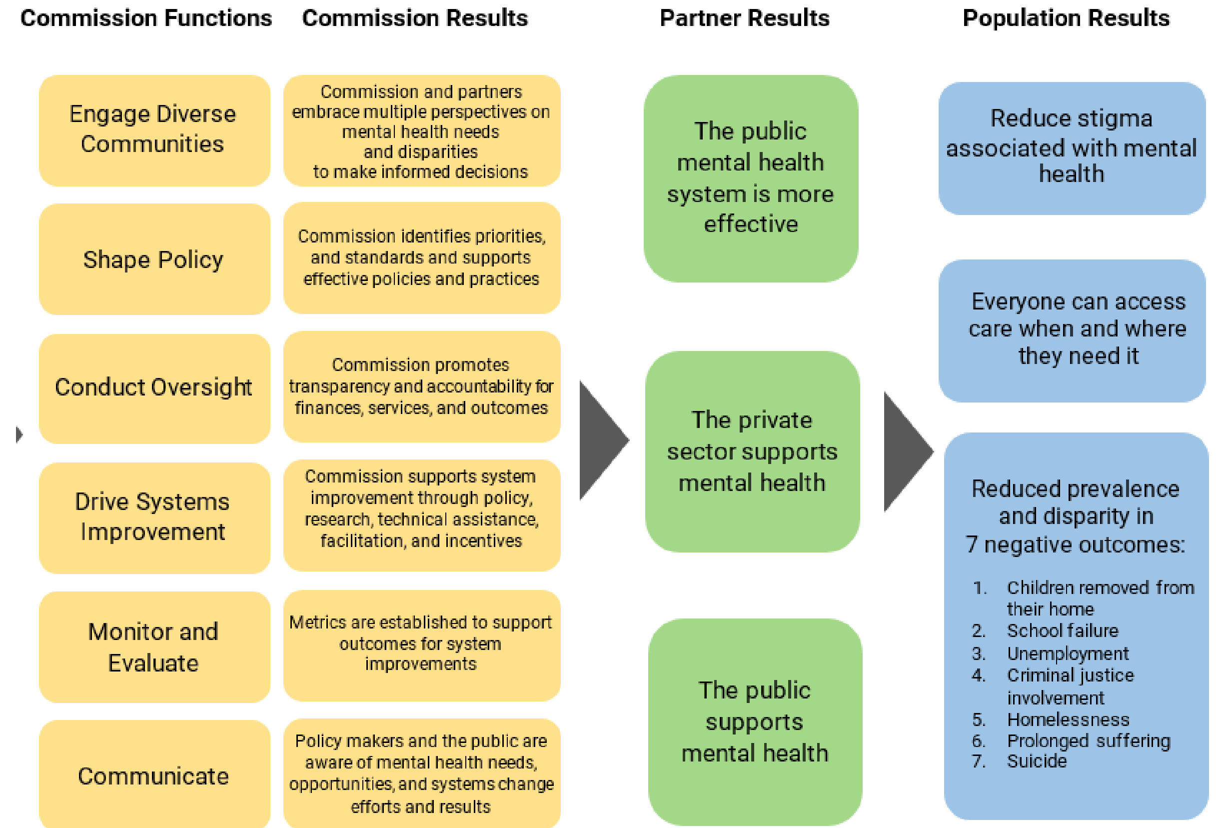
Results Framework:

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 *

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
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		% 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

California Mental Health Services Oversight and Accountability Commission Scorecard

This example scorecard was created to demonstrate the capabilities of the system to organize state-wide, county and program data for better planning and measurable improvement so that "Everybody who needs care gets care when and where they need it."

California's Population Will Be Better Off

	Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
R Positive outcomes across counties are increased					
I # of children removed from their home					
I High school graduation rate					
I Unemployment rate					
I Criminal justice involvement rate					

Story Behind the Curve | Partners | What Works | Strategy | What We Do

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.

Susan Brutschy
susan@appliedsurveyresearch.org

Lisa Colvig-Niclai
Lisa@appliedsurveyresearch.org

www.appliedsurveyresearch.org

AGENDA ITEM 7

Information

September 26, 2019 Commission Meeting

Executive Director Report Out

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

Presenter:
- Toby Ewing, Executive Director, MHSOAC

Enclosures (8): (1) Motions Summary from the August 22, 2019 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) County Presentation Guidelines; (5) Siskiyou County Innovation plan Extension Request; (6) Siskiyou County Innovation Plan Staff Analysis; (7) Calendar of Tentative Agenda Items; (8) Department of Health Care Services Revenue and Expenditure Reports Status Update; (9) Legislative Report to the Commission.

Handouts: None.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motions Summary

Commission Meeting
August 22, 2019

Motion #: 1

Date: August 22, 2019

Time: 9:27 AM

Motion:

The Commission approves the May 23, 2019 Meeting Minutes.

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Bunch

Motion carried 7 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	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
August 22, 2019

Motion #: 2

Date: August 22, 2019

Time: 9:29 AM

Motion:

The Commission approves the June 10, 2019 Teleconference Meeting Minutes.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Wooton

Motion carried 7 yes, 0 no, and 3 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	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motions Summary

Commission Meeting
August 22, 2019

Motion #: 3

Date: August 22, 2019

Time: 9:30 AM

Motion:

The Commission approves the July 25, 2019 Meeting Minutes.

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Berrick

Motion carried 5 yes, 0 no, and 5 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
31. Commissioner Alvarez	☐	☐	☒
32. Commissioner Anthony	☒	☐	☐
33. Commissioner Beall	☐	☐	☐
34. Commissioner Berrick	☒	☐	☐
35. Commissioner Boyd	☐	☐	☐
36. Commissioner Brown	☐	☐	☐
37. Commissioner Bunch	☒	☐	☐
38. Commissioner Carrillo	☐	☐	☐
39. Commissioner Danovitch	☐	☐	☒
40. Commissioner Gordon	☐	☐	☒
41. Commissioner Madrigal-Weiss	☒	☐	☐
42. Commissioner Mitchell	☐	☐	☒
43. Commissioner Wooton	☐	☐	☒
44. Vice-Chair Ashbeck	☐	☐	☐
45. Chair Tamplen	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motions Summary

Commission Meeting
August 22, 2019

Motion #: 4

Date: August 22, 2019

Time: 10:43 AM

Motion:
The Commission approves Alameda County's Innovation plan as follows:

Name: Supportive Housing Community Land Trust (CLA)
Amount: $6,171,599
Project Length: 5 years

Commissioner making motion: Commissioner Boyd

Commissioner seconding motion: Commissioner Mitchell

Commissioners Berrick and Tamplen recused themselves. Motion carried 8 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	☐	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motion #: 5

Date: August 22, 2019

Time: 11:00 AM

Motion:
The Commission:

- Authorizes the Executive Director to issue a “Notice of Intent to Award Contract” to the highest scoring proposer: California Youth Empowerment Network (CAYEN) A Program of Mental Health America of California.
- Establishes August 29, 2019 as the deadline for unsuccessful bidders to file an “Intent to Protest” and September 6, 2019 as the deadline to file a letter of protest consistent with the requirements set forth in the RFP.
- Directs the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.
- Authorizes the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.

Commissioner making motion: Commissioner Wooton

Commissioner seconding motion: Commissioner Gordon

Motion carried 8 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	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 6

Date: August 22, 2019

Time: 11:10 AM

Motion:
The Commission adopts the draft amendments to the conflict of interest code and authorizes the Executive Director to take the necessary steps to begin the rulemaking process and to submit the code with the supporting documentation as required by law.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Danovitch

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	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 7

Date: August 22, 2019

Time: 1:25 PM

Motion:
The Commission approves the final FY 2018-19 expenditures and the proposed FY 2019-20 budget as presented.

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Commissioner Anthony

Motion carried 8 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	☐	☐	☐

Motion #: 8

Date: August 22, 2019

Time: 2:33 PM

Motion:
The Commission opposes Senate Bill 665 (Umberg).

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Anthony

Motion carried 5 yes, 1 no, and 2 abstain, per roll call vote as follows:

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: **4**

Funds Spent Since the August Commission Meeting

Contract Number	Amount
17MHSOAC081	$125,000
17MHSOAC085	$0
18MHSOAC020	$17,700
18MHSOAC040	$0
Total	**$142,700**

Contracts with Deliverable Changes

17MHSOAC081

17MHSOAC085

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Evaluation Dashboard September 2019
(Updated September 11th, 2019)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Deliverable	Status	Due Date	Change
Summary Report (3 Public Engagements)	Complete	6/30/19	Yes
Outcomes Reporting Draft Report —3 Sections	In Progress	9/31/19	Yes
Outcomes Reporting Draft Report – 4 Sections	Not Started	12/31/19	No
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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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: $100,405

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)	Under Review	09/07/19	Yes
FSP Formatted Data Sets (Orange & Ventura)	In-progress	09/30/2019	Yes
FSP Draft Report	Not Started	10/28/19	Yes
FSP Final Report	Not Started	12/31/19	Yes

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

MHSOAC Staff: Rachel Heffley

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

Total Contract Amount: $310,743

Total Spent: $284,118

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	12/31/19	Yes

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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: $0

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	Not Started	09/30/19	No
Quarterly Progress Report	Not Started	12/31/19	No
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

Mental Health Services Oversight & Accountability Commission

INNOVATION DASHBOARD
SEPTEMBER 2019

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	5	7	**12**
Participating Counties (unduplicated)	5	5	**9**
Dollars Requested	$7,123,296	$9,998,517	**$17,121,813**

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	2	2	$6,689,779	2 (3%)

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)

PROJECT DETAILS

FINAL PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Glenn	Crisis Response and Community Connections (CRCC)	$787,535	5 Years	3/26/2019	5/31/2019
On Consent	Sutter-Yuba	Innovative and Consistent Application of Resources and Engagement (iCARE)	$5,228,688	5 Years	5/6/2019	6/17/2019
Under Review	Napa	Statewide Early Psychosis Learning Health Care Network	$251,286	5 Years	4/30/2019	7/16/2019
Under Review	San Luis Obispo	Holistic Adolescent Health	$660,000	4 Years	3/21/2019	7/25/2019
Under Review	San Francisco	Addressing Socially Isolated Older Adults (extension)	$195,787	5 Years	N/A	4/5/2019

DRAFT PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	San Luis Obispo	San Luis Obispo Threat Assessment Program (SLOTAP)	$879,930	4 Years	3/21/2019	Pending
Under Review	El Dorado	Senior Health and Nutrition	$912,000	2 Years	4/30/2019	Pending
Under Review	El Dorado	HUBS Project (extension)	$2,158,704	1 Year	4/30/2019	Pending
Under Review	Colusa	Social Determinants of Rural Mental Health Project	$161,200	3 Years	8/30/2018	Pending
Under Review	Stanislaus	NAMI On Campus High School	$923,259	5 Years	7/5/2019	Pending
Under Review	Stanislaus	Whole Health Approach to Improve Mental Health Outcomes	$4,499,000	5 Years	7/5/2019	Pending
Under Review	Butte	Physician Committed (extension)	$464,424	3 Years	7/25/2019	Pending

COMMISSION MEETING PRESENTATION GUIDELINES

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
   a. County presentations should be no more than 10-15 minutes in length
   b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
   c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **County Brief**
   a. Recommend 2-4 pages total and should include the following three (3) items:
      i. Summary of Innovation Plan / Project
      ii. Budget
      iii. Address any areas indicated in the Staff summary

3. **PowerPoint Presentation**
   a. Recommend 5 slides and include the following five (5) items:
      i. Presenting Problem / Need
      ii. Proposed Innovation Project to address need
      iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
      iv. Innovation Budget
      v. If successful, how will Innovation Project be sustained?

4. **Presenters and Biographies**
   a. We request no more than a few (2-4) presenters per Innovation Project
      i. If the county wishes to bring more presenters, support may be provided during the public comment period
   b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
      i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

Considerations for reviewing an Innovation Extension Request

Background:

Learning Goal: *Increase the quality of services, including better outcomes*

Siskiyou County Behavioral Health Division's (BHD) Innovation Plan, the *Integrated Care Project* (ICP), was approved by the Oversight and Accountability Commission in February of 2016. The purpose of this ICP is to increase the quality and continuity of health care services, and to improve outcomes for adults diagnosed with co-occurring serious physical health and mental health conditions. Information gathered through the MHSA community planning process, and by a collaborative Blue Shield grant funded project focused on health care integration, illustrated the need to improve access and coordination of physical health and behavioral health services to improve client outcomes. Stakeholders identified a need to improve the coordination and integration of health care and follow-up services for consumers receiving behavioral health and physical health care in Siskiyou County. Community based health care is a limited resource in many rural communities. Fairchild Medical Clinic, a rural healthcare clinic located in Yreka, is partnering with BHD to develop an integrated health care system that ensures the availability and accessibility of behavioral and primary health care services to individuals with co-occurring disorders. This vision of integrated care will provide an important foundation for developing and expanding care coordination for behavioral health clients. A primary goal of the project is to develop a model for coordination and integration of services that may be implemented throughout the county.

Implementation of the ICP began in FY 16/17. In August 2016, the ICP team engaged Praxis Consultants to assist with project planning and outcome development. Shortly thereafter a treatment team was identified comprised of a project manager, BHD Clinician, Behavioral Health Specialist (case manager) and LVN, and an LVN employed by Fairchild Medical group. In addition, management and supervisory staff from each clinic, and the Fairchild Medical Director participated in initial program development workshops. Concurrently, consumers were identified who met eligibility criteria and were offered the opportunity to participate in the pilot project.

Procedures began to be developed by the team and documents were created for the purpose of intake, orientation, and data collection to measure progress and outcomes. Software licenses were purchased for ICP team members to allow real-time, confidential client information to be shared between providers. A new vehicle was purchased to facilitate timely transportation for ICP consumers to and from appointments. Consumers and team members determined it would be helpful to issue identification cards for ICP participants to facilitate identification and coordination of care by providers including the local ER.

ICP staff began serving clients in May of 2017, however it took several months for initial appointments to be scheduled and attended. During the initial stages of implementation, project assessments were conducted, consumers signed participation agreements and completed orientation. Although fifteen consumers were identified to participate in the project initially, only eleven were enrolled in the ICP program and over the course of the first year attrition occurred reducing enrollment to eight. It was anticipated that this number would increase in FY 17/18, however, several challenges presented

themselves as the project continued which resulted in delays in enrollment. One challenge that was discovered was that this group of participants in the ICP required such high level of services that the team members weren't equipped with enough time to serve their needs and without the addition of Peer Support Providers and a BHD Nurse adding more clients was not a possibility. An additional challenge that was identified was the high need for specialty medical intervention and the specific challenges our mental health clients face when attempting to access these services. Most specialty medical care is over 3 hours round trip from Yreka and therefore takes a great deal of time to transport and advocate with these clients. These challenges reduced capacity and created additional difficulties with regard to tracking, collecting and updating data for the eight clients enrolled in the program. We were able to address some of these issues by assigning a BHD nurse to the program, and hiring Peer Specialists to support consumer participants. There are a few challenges that continue to exist. One is the narrow access point for this integrated care project and the other is reassigning clients to a specific team while participating in ICP. Through this innovative process, we have found that the sustainable integration of physical and behavioral healthcare will entail *moving from a cohort-based model,* conceptualized as a standalone program with a dedicated staff, *to one that expands access* and embraces whole person care for all clients with chronic physical and mental health conditions. As we move forward with this model, we will incorporate training for all providers to focus on whole person care, thereby increasing access and building a sustainable system to serve these clients with specialty needs.

One of the objectives identified as an important component of the overall ICP is the development of effective engagement and retention strategies for consumers with complex medical, mental health and/or substance use issues. As a result of consistent engagement in services, consumer outcomes are anticipated to include increased decision making regarding care, improved nutrition, improved medication adherence, increased feelings of safety and respect from healthcare providers, reduced hospital/crisis events and increased self-advocacy. As with all MHSA programs, ICP is consumer and/or family driven and therefore ICP providers work closely with consumers to identify services that can help support wellness goals. Similar to Full Service Partners (FSPs), consumers enrolled in ICP require a high level of engagement, support, and skill building to navigate successfully through healthcare systems and advocate for themselves with providers.

The majority of the ICP enrolled participants meet criteria for FSP services, and have access to flex funds which provide non-traditional services and supports to facilitate progress toward meeting treatment team goals. Examples of these services include, but are not limited to food, housing, prescription or over-the-counter medications not covered by Medi-Cal and transportation to assist with getting to medical and mental health appointments. Consumers enrolled in this pilot project and the providers serving them have determined that extending the availability of flex funding to all ICP participants, when appropriate, will support the goals and objectives of the ICP and these funds will be available to all ICP consumers in FY 18/19 and through the duration of the project.

Implementation of peer support services began in early 2018. Two county funded part-time peer positions were added to the existing Behavioral Health team. The new peer providers have lived experience with mental health or physical health challenges and have been integrated into the ICP to provide support and mentoring for enrollees. Peer support has been proven to promote wellness and recovery among individuals suffering from mental and/or physical health challenges. Peer Specialists provide support, mentoring, and advocacy for consumers enrolled in the ICP program.

A second quarter review was conducted to evaluate processes, review data and determine necessary adjustments to the program and revealed the following: 1) ICP clients and their family members indicated a desire to participate in Six Stones Wellness Center and a need for transportation to facilitate access; 2) participants requested groups specifically for ICP program members be implemented; 3) the importance of peer support was noted; and 4) multi-disciplinary team (MDT) meetings were identified as an important component of the project. Team members reviewed participant feedback and services and identified strategies to mitigate challenges. The ICP team will continue to conduct quarterly reviews to evaluate progress, and will incorporate feedback from clients and staff as appropriate.

Over the first year of implementation, Office 365 software licenses were purchased to allow for data sharing between clinics. Although useful in providing team members with access to real time data on mutual clients, data must be input manually by ICP staff which is extremely time consuming and provides very limited reporting options. For reporting and evaluation purposes, it is difficult to pull data from the multiple electronic health systems utilized for ICP consumer care. In addition, the State reporting requirements have changed, and there is a demand for more succinct data. To better meet the needs of evaluating the ICP project, we purchased a data suite. This additional software will allow for analysis of data from the electronic health records as well as reporting outcomes to the State. New software has the capability of pulling data from multiple providers and sources to create necessary reports for analyzing and determining program improvements. One of the sources is the Data Collection Reporting System through Behavioral Health Information Systems (BHIS) where FSP data is stored. As stated previously, many of the ICP consumers also qualify for FSP and are tracked through the BHIS system.

As the program grew, the team identified the need for targeted clinical oversight and focused treatment modalities for clients with co-occurring disorders. The appointment of a clinical lead assists the team in assuring that each treatment modality fits the client's unique needs. As reported during both quarterly reviews, clients have expressed a desire for higher participation in Six Stones Wellness Center programs and the need for transportation to and from this program. Participants also requested specific groups be implemented to support program members and their families in areas such as smoking cessation, nutrition and exercise. BHD will collaborate with Six Stones to create this additional support as well as expand transportation to ensure clients can access requested services.

As the program progresses, the department will continue to develop protocols and procedures to support and adapt the innovative services being provided by the ICP. Consultants will work with county staff to collect, organize and analyze data and to evaluate the program for effectiveness. Additional consumers will be added to the program by improving access and allowing clients to continue to be served by their original therapist and case manager. New software tools purchased through the data suite will be used to track program data with increased efficiency and accuracy.

REQUEST TO INCREASE FUNDS FOR INTEGRATED CARE PROJECT (ICP)

Discussion:

Did the Commission approve the original plan?

> Yes, Siskiyou County's ICP Innovation Project was approved on February 26, 2016 by the Oversight and Accountability Commission. Locally, the FY 15/16 annual update, which included

the Innovation Plan, was presented to stakeholders during several focus groups and ultimately approved by the Siskiyou County Board of Supervisors on January 5, 2016.

Is there documentation of a community planning process for the extension?

Several Stakeholder Groups were hosted by Behavioral Health to solicit input and feedback from community members in April 2018. Participants included but were not limited to law enforcement, adult and older adults with severe mental illness, veterans, healthcare and substance use disorder providers, non-profit organizations and families with children. During these focus groups staff provided information about the current status of the Innovation Project, the challenges the Department faced during the initial start-up, the potential reversion of Innovation dollars, and the County's AB114 spending plan. This information and AB114 plan is also included in detail in the FY 18/19 Annual Update. In addition to facilitating stakeholder groups, the County also circulated the draft Plan in hardcopy and electronically, as well as posting on the Siskiyou County MHSA website.

Is the extension for time?

No, the original plan was approved for 5 years, which is the maximum allotted time for innovation projects.

Is the extension because the plan was not started when estimated in the plan proposal?

No. Although the plan was originally approved by the OAC in February, 2016, the MHP did not expend any funds until October of 2016, therefore the ICP project can proceed until October 2021 with the approval of additional funds.

Has the learning objective changed?

The learning objectives have not changed. We are still focusing on providing increased quality of services with better outcomes. We are gearing up to improve the access point for qualifying for this program, which will in turn add more recipients. We have learned how much chronic physical health ailments directly affect a client's mental health and vice versa and have shared this information with our medical and mental health providers to add perspective to how we provide care. Through interviews with clients we have learned that outcome data such as lab results and other medical statistics may not properly reflect the true level of increased wellbeing felt by the clients. Clients report they are "feeling better" and show increased motivation even if some of their test results don't medically support those outcomes. By incorporating peer support, we've added another layer of support to our clients to assist with advocating for increased understanding of the care being provided to them, and giving them a better sense of control over their healthcare. These are all important factors for providers to take into consideration when working with clients and can be integrated into services for all mutual mental health and physical health clients. At the conclusion of the program, a complete evaluation on all the lessons learned and innovative services we plan to incorporate into our clinic will be provided to the State for sharing with other counties.

Has the population changed (including the subject, test, or "n" population)?

The population originally chosen for this project; adults with serious mental illness who are at risk for, or have, a chronic health condition, has not changed. However, these consumers have proven to have extremely high needs which, due to capacity, has limited the number BHD is currently able to serve. The coordination of care between primary care, mental health providers, specialists, physical therapy, lab work, as well as case management, transportation and other healthcare navigation requirements exceed the capacity of the staff currently assigned to the program. BHD intends to expand the number of program participants and is currently planning to expand the access process without changing the target population. Clients will be allowed to stay with their original therapist, which will increase the overall ICP team and allow for more clients to be served. The lesson learned was that having a very small clinical team didn't allow this program to grow due to the high needs of the client population.

Is the extension requested to increase the funding for the Innovation?

Yes.

What is the reason for additional funds?

Evaluation of time studies revealed that significant staff time is dedicated to assisting consumers to navigate the healthcare system. Specific tasks include scheduling and re-scheduling medical appointments, mentoring and advocacy, arranging for transportation, and assuring necessary records are provided to specialists. The ICP team has determined that the role of Health Navigator is essential to developing a successful integrated care model. An increase in funding for the ICP will allow the BHD to hire this Health Navigator to streamline access and coordination to an increased number of participants in the program. Their role will be to help the client navigate the physical health care system through embedding this Navigator into FMC facility. It's clear that improved communication between health clinics, doctors, nurses, case managers and clinicians, is extremely important for the consistent care of these clients. The current staffing level has struggled with this, as well as getting the clients to all their medical specialist appointments, which is usually a 3-hour round trip. Due to clients' diagnosis and mental health struggles, peers or case managers are accompanying clients to these appointments to help advocate for care, document conversations, ensure follow up and model positive behaviors and provide coping skills while clients are experiencing stressful situations. This takes additional staff time and reduces the number of services that can be provided and the number of clients that can be seen on any given day. Therefore, funds were still being spent on staff, but less clients could receive services due to the intensity and time it was taking per each client.

The BHD has worked with a contractor to assist with program evaluation and development of strategies to meet learning objectives. This work, due to issues with data collection, sharing, and analysis and other barriers encountered has required an increase in the contract amount for consultation.

During the initial implementation of the ICP, a vehicle was purchased for consumer transport to medical and mental health appointments as well as to other ICP activities. Two Peer Specialists were added to the ICP team to provide specialized support and wellness activities focused on recovery and independence.

In an effort to increase the quality of services, more efficient and accurate communication is necessary between primary care doctors and mental health providers. In a rural setting such as Siskiyou County, it

is not feasible to have co-located providers and communication occurs through conventional means such as email, fax and telephone. The ICP piloted a new HIPAA compliant database that allows for sharing of information, however, it has proven to be cumbersome for staff to update. Therefore, the BHD continues to research less labor intensive, more efficient ways to share information including data warehousing and other software options. The team will continue to work on integrating improved communication techniques as we transition and grow the program.

If the plan has been executed and seems successful, why isn't the county considering transferring the services to another MHSA component?

The County has not had time to fully evaluate the program. Over the next 18 months, the team will be expanding services to more clients and working on procedures to transition the services into mainstream BHD case management and therapy with a whole-person care focus and enhanced communication with medical providers.

Conclusion:

Over the first two years of serving clients, the Siskiyou Integrated Care Project Team has learned that mental health clients with chronic health ailments need very focused, intense support when first entering the program, and sometimes ongoing, depending on their diagnosis. This requires a lot of staff time to organize, communicate, schedule and transport to the initial, as well as follow up, medical appointments.

While trying to meet the needs of the ICP clients, we soon learned it was overwhelming for staff to properly serve the unexpected increased demand and try to expand the program by adding new clients. In the approved program proposal, the expectation was to start with 15 clients and increase to 30 because that is the 'normal' caseload for BHD case managers. However, we quickly discovered through feedback from the ICP case manager and medical nurse that these weren't 'normal' clients with 'normal' service needs. We felt it was part of the innovation of the Program and our responsibility to acknowledge these differences and address the challenges before bringing on additional clients that we may not be able to serve to the level necessary. Our consultants helped guide the team to identify the gaps and determine ways to mitigate the barriers. We have since hired clinical oversight to provide support and guidance to the case manager, peers and entire team. We also identified the need for a Health Navigator, as mentioned previously. Due to the increased need for transportation for program participants, we will expand our contract with Six Stones to include a new van and driver allowing clients easier access to programs at the Wellness Center as requested through interviews and evaluation. It is anticipated that these additional positions and services will provide some relief to the current team, allowing them to distribute responsibilities and job duties resulting in expanding the program as originally intended.

The Siskiyou Integrated Care Project was approved for five (5) years in February 2016, for a total of $710,858. The date of the first expenditure was October 2016. Based on the details outlined above, Siskiyou County respectfully requests an increase to the budget through the conclusion of the project in October 2020. The total additional amount requested is $518,180 which would bring the total Project expense by October 2020 to $1,229,038. The increase in funds will be focused on staff, evaluation, contract and expansion and increased collaboration of services provided at Six Stones Wellness Center.

This increase will also allow the County to use the reallocated reverted funds of $774,105 as outlined in our AB114 spending plan. The AB114 plan was included in the FY18/19 MHSA Annual update and approved by the Board of Supervisors on June 19, 2018. The BHD intends to spend the funds that were subject to reversion during the 18/19 and 19/20 fiscal years as outlined in the budget below.

Proposed Budget by Fiscal Year and budget category

	FY15/16	FY16/17	FY17/18	FY18/19	FY19/20	July '20-Oct '20	
1. PERSONNEL	$ -	$ 50,416	$ 155,318	$ 192,000	$ 252,000		$ 649,734
2. OPERATING EXP	$ -	$ 417	$ 13,216	$ 14,000	$ 14,000		$ 41,633
3. NON-RECURRING	$ -	$ 29,520	$ -	$ 52,000	$ -		$ 81,520
4. CONTRACT	$ -	$ 56,077	$ 77,093	$ 99,100	$ 160,427	$ 21,000	$ 413,697
5. OTHER EXP	$ -	$ 770	$ 11,685	$ 15,000	$ 15,000		$ 42,455
TOTAL PROPOSED EXP	$ -	$ 137,200	$ 257,311	$ 372,100	$ 441,427	$ 21,000	$ 1,229,038
MHSA revenue	$ 128,429	$ 149,169	$ 161,184	$ 155,154	$ 140,000	$ 140,000	$ 873,936
MED-CAL FFP	$ -	$ -	$ 43,000	$ 45,150	$ 47,410	$ 47,410	$ 182,970
							$ -
							$ -
total revenue	$ 128,429	$ 149,169	$ 204,184	$ 200,304	$ 187,410	$ 187,410	$ 1,056,906
Inn funds to be approved		$ 137,200	$ 257,311	$ 372,100	$ 441,427	$ 21,000	$ 1,229,038

Budget Narrative:

A. Expenditures

Personnel Expenditures: Salaries and benefits for estimated FTE's including costs associated with personnel for case management, clinical services, data collection, evaluation, oversight, peer support and reporting.

Fiscal Year 16/17 administrative oversight, including planning and MHSA Coordinator salary plus two part time Peer Specialists. Fiscal year 17/18 figures include 1 FTE Behavioral Health Specialist, admin support, two 0.5 FTE Peer Specialists, approximately .25 FTE Clinician. Current and future fiscal years reflect an additional 1 FTE Health Navigator.

Operating Expenditures: Estimated costs associated with the day-to-day operations of the project/plan. Includes supplies, insurance or fees, travel and/or transportation, on-going medication and/or medical supplies, mileage, expenses for travel, and client supportive services. Supplies may include medical or medication management supplies not covered by insurance to assist with measuring outcomes and assist with patient health progress

Non-Recurring Expenditures: Estimated one time cost. Items including office equipment and computers for new staff. One vehicle will be purchased for Six Stones Wellness Center to expand transportation for clients in the program and connect to wellness activities.

Contracts: Costs associated with evaluation of program and contract staff with partnering agencies. Also may include MOU's with partners to ensure additional support for participants. Increased contract with

Six Stones to incorporate staff assistance with client transportation to wellness appointments and Six Stones activities and to support activities of daily living. This will provide time for BHD staff to provide more Medi-Cal billable services.

Other Expenses: Wellness/Recovery incentives through the ICP Flex fund program such as gym memberships, gift cards, fitness gear, housing, food, vehicle registration, and other assistance identified by clients to support their health and wellness goals.

B. REVENUES

Federal Financial Participant: Estimated possible revenue from FFP. Estimates are based on data secured from current programs with similar elements to this model. Once the reallocated reverted funds are utilized, the Department will apply program revenue to the project when services qualify to be billed and revenue is received.

Siskiyou County currently has a fund balance that will be used to cover costs as the program progresses and is evaluated. Funds will be spent pursuant to AB114 regulations outlined in Exhibit J of the approved MHSA FY 18/19 Annual Update. Per regulation, AB114 'reallocated' funds will not be spent until the 18/19FY. Therefore, the expenditures in the 16/17 and 17/18 fiscal year ($394,511) will be charged to the revenue received in FY14/15 through 17/18. Once those years' expenditures are applied, the MHP will use reallocated funds beginning in FY08/09 through 13/14, a total of $774,105, to apply towards expenditures in FY 18/19 through 19/20. The balance after reallocated funds are expended will be charged to revenue received in FY17/18 and so forth.

STAFF ANALYSIS – SISKIYOU COUNTY

Innovative (INN) Project Name:	**Integrated Care Project (formerly called Health Care Coordination): Extension Request**
Extension Funding Requested for Project:	**$518,180**

Review History:

MHSOAC Original Approval Date:	February 25, 2016
Approved by the BOS:	June 19, 2018
County Submitted Innovation (INN) Project:	April 19, 2019
Staff Analysis Completed:	August 6, 2019

Project Introduction:

In February 2016, Siskiyou County received Commission approval of up to $710,858 of innovation spending authority over five (5) years for an innovation project which would improve the integration and coordination of health care (physical and behavioral) for those receiving behavioral health care services in the County. These services were targeted towards individuals diagnosed with co-occurring serious physical health and mental health conditions.

The project started in October 2016 and began delivering services in May 2017. Since the County began delivering services, there have been significant delays in implementation due to the extremely limited staff resources. Additionally, the County encountered the following challenges in the early stages: (1) The County underestimated the high level of need this population required and did not employ enough staff to provide the necessary time and services, (2) many of the clients also required specialized medical services which requires more than a three-hour drive round-trip (a service provided a part of this project), and (3) a more integrated software program for multiple service providers. In order to meet some of these needs, the County added a behavioral health nurse and a peer specialist to support these clients. However, there are still challenges remaining.

Siskiyou County is requesting up to an additional $518,180 of innovation spending authority to address the above by incorporating additional personnel, transportation, software to facilitate the sharing of client information, increased consultation costs, and the incorporation of additional programs into the Six Stones Wellness Centers.

The Need

The County, in multiple discussions with Commission staff, has indicated that it has encountered several unanticipated challenges that have prevented the County from sufficiently evaluating client outcomes against the original learning objectives of the project. On October 30, 2018, , Commission staff discussed additional options regarding the utilization of innovation funds should the project not be successful. However, the County has indicated it remains strongly committed to the original learning objectives of the project. The County strongly feels that seeking additional funding to incorporate these new elements will allow the project to succeed. Additionally, Siskiyou County has very limited resources in terms of staffing and embarking upon a brand-new project would be deemed a hardship. For these reasons, the County would like to proceed with seeking additional funding for this project extension request.

The County contracted with consultants (Praxis) in August 2016 to assist the County with the planning and development of the project followed by the creation of a treatment team that consisted of a project manager, clinician, case manager, and a behavioral health nurse.

Due to the challenges described above, the County has not been able to successfully provide the services needed by their clients and measure the outcomes of what has been provided thus far effectively.

The Response

In order to remedy the residual challenges, the County would like to add components to this project to include a health navigator, additional transportation, additional activities offered thru the County's Wellness Center, and the research and purchase of software that allows data sharing while adhering to data privacy.

Siskiyou County intends on using the additional funding to meet the following needs:

- Obtain sufficient staffing for clients with multiple, complex needs,
- Acquire adequate transportation, and
- Research and purchase a more integrated software program to allow the client's data to be collected across multiple providers.

The County's quarterly reviews of the project and lessons learned revealed that additional components were needed for this project to be successful:

1. Participation in programs offered by the County's Wellness Center, including transportation
2. Purchase of software and increased contract consultation
3. Adding a health navigator position to assist participants in navigating thru the behavioral and physical health care system

The innovation project reflected that participants in the project expressed a need for more support in reaching health and wellness goals and being able to access programs offered by the Six Stones Wellness Center programs. As a result, the County states they will

contract and collaborate with the Wellness Center to provide additional support by offering various programs to clients. Transportation for clients will be provided to appointments at the Wellness Center as well as specialty appointments located in other parts of the County. For this reason, the County states they will purchase one additional vehicle to transport clients to appointments as needed.

In addition to the clinician, behavioral health nurse, case manager and peers that were hired for the original project, the County indicated the staffing model that was in place was not enough to serve the needs of the target population and that a Health Navigator would be vital for establishing an integrated care model to assist in the streamlining access and coordination of program participants.

In consultation with the program evaluations contractor, the County discovered there were challenges with data collection, sharing, and analysis which ultimately required an increase in the contract amount for consultation. Although software licenses were purchased in the first year of implementation to facilitate data sharing between clinics, the County found that this provided limited reporting options. After consulting with the contractor (Kingsview) for collecting data from electronic health records, it was concluded that a data suite would need to be purchased. This additional software would allow data to be pulled from multiple providers and sources which would assist in reporting outcomes and determining program enhancements. One of the data suites being considered has the ability to retrieve data from the Data Collection Reporting System which houses Full-Service Partnership (FSP) data. Many of the participants in this project qualify for FSP services and are currently tracked through this system, which would facilitate data sharing, tracking and analysis.

The Community Program Planning (CPP) Process

The CPP for this extension was formally conducted as part of the County's FY 18/19 MHSA Annual Update. The 30-day public comment period began May 1 through May 30, 2018; followed by a public hearing on June 18, 2018 and Board of Supervisor approval, which was received on June 19, 2018.

In April 2018, the County held several focus groups that included but not limited to law enforcement, adult and older adults with severe mental illness, veterans, providers, non-profit organizations and consumers and family members. Participants in the focus groups shared their thoughts on the status of the ongoing innovation project, identified the challenges and barriers, and discussed strategies to remedy the barriers.

This extension request was initially shared with Commission stakeholders on March 25, 2019 and received one comment via email from the Executive Director of United Parents. The email indicated that there were good outcomes in the first year of implementation despite the small number of program participants. Additionally, there was a recommendation for the program to assist clients to become more independent and lessen the client's use of community supports and to focus more effort on the involvement of family.

The Final version of the extension was then shared with stakeholders on June 5, 2019 and no letters of support or opposition were received.

Learning Objectives and Evaluation

Siskiyou County will continue to evaluate the overall success of the Health Care Coordination project, including the effect that coordination has on increasing the quality of mental health services (primary purpose). The County originally estimated that around 30-clients would be served by the project annually, however, after implementation, it was determined that the target population—individuals 18-years and older with serious mental illness who are at risk, or have, a chronic health condition—have higher needs than anticipated. The target population will not change, however, other programmatic changes discussed elsewhere in this analysis will be made to ensure more clients will be served by the project.

The evaluation for the Health Care Coordination project will not change from that in which was originally approved by the Commission. The County reports that lessons have already been learned, including validation that chronic physical health ailments affect the mental health of individuals served in the program. The County will continue collecting data at both the client level to evaluate the program's ability to meet improved outcomes, such as improved health indicators (i.e. body mass index, blood pressure, A1c, cholesterol, substance use), as well as at the programmatic level (i.e. persons screened, participation in wellness activities, linkage to primary care, medication management). Additionally, the County will continue collecting data to better understand the collaborative efforts of the program by using the Interagency Collaboration Activities Scale in a survey with participating agency staff.

In the original plan approved by the Commission, the County stated that the evaluation and evaluation activities would be developed with guidance from the developed Health Care Coordination Advisory Board and the Behavioral Health Quality Improvement Committee.

The Budget

The County is seeking to use $252,000 of the additional funding for personal expenditures (49% of the total extension request) which will include salary and benefits for the following staff: a Behavioral Health Specialist, two (2) half-time peer specialists, administrative support, a Health Navigator, a case manager as well as a part time clinician.

Consultant costs (Praxis) for the evaluation of this project in the amount of $70,850 represent 13.7% of the additional request. The contractor (Kingsview) who will facilitate extracting and organizing data from electronic health records will cost an additional $6,000 (1.2% of additional request). The County is seeking to fund the Fairview Medical Clinic, the partner in this project, an additional $54,000 (10.4% of additional request) to ensure that there are available and accessible behavioral and primary health care services provided for those individuals with co-occurring disorders. The County will enter into a contract in the amount of $50,577 (9.8% of the additional request) with Six Stones Wellness Center to ensure program participants receive adequate assistance, activities, and transportation.

Operating expenditures are estimated to cost $14,000 and will cover the day to day operations to include supplies, medication costs, travel expenses and medical supplies.

The County has opted to offer incentives in the amount of $15,000 to support clients in reaching their health and wellness goals. Incentives may include gym memberships, fitness gear, gift cards, etc.

Siskiyou County indicates they have a remaining fund balance for this project in the amount of $55,755. This amount will likely cover any remaining expenses from FY 18/19 to include the purchase of an additional vehicle for transporting clients to and from appointments and any other unpaid expenses remaining from this current fiscal year.

Pursuant to Assembly Bill 114, the County is utilizing a total of $774,105 for this entire project (original approved amount plus extension request) that are subject to reversion as outlined in the County's MHSA FY 18/19 Annual Update.

Additional Regulatory Requirements

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

Comments

If extension is not approved, County can also consider purchasing the data suite utilizing the Capital Facilities Technology Needs (CFTN) component.

References

What is Integrated Care?
https://www.integration.samhsa.gov/resource/what-is-integrated-care

Calendar of Tentative Commission Meeting Agenda Items

Proposed 09/18/19

Agenda items and meeting locations are subject to change

October 24: San Diego, CA

- **Rules of Procedure**
  The Commission will consider amendments to the Rules of Procedure.

- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

November 21: TBD

- **Suicide Prevention Strategic Plan**
  The Commission will be presented with the Final Statewide Suicide Prevention Strategic Plan.

- **Mental Health Student Services Act outline for the RFP**
  The Commission will consider approval of an outline for the Mental Health Student Services act RFP.

- **Stakeholder Outline for the RFPs**
  The Commission will consider approval of an outline for stakeholder RFPs.

- **UCLA Community Wellness Measures and Outcomes Report**
  The Commission will hear a presentation on the UCLA Community Wellness Measures and Outcomes Report.

- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

December: No Meeting Scheduled

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 September 12th, 2019.

This Status Report covers the FY 2014-15 through FY 2017-18 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.

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 http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

On July 1, 2018 DHCS published a report detailing MHSA 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). The report details all funds deemed reverted and reallocated to the county of origin for the purpose the funds were originally allocated. The report can be accessed at the following webpage: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

DHCS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 14-15		FY 15-16		FY 16-17			FY 17-18		
	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018		1/3/2018	3/25/2019	3/26/2019	4/9/2019
Alpine	6/26/2017	6/26/2017	11/22/2017	11/27/2017	7/23/2018		7/23/2018	5/10/2019	5/13/2019	5/15/2019
Amador	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018		4/13/2018	12/19/2018	12/19/2018	12/21/2018
Berkeley City	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018		2/1/2018	12/28/2018	1/2/2019	1/8/2019
Butte	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018		5/7/2018	6/26/2019		6/26/2019
Calaveras	1/4/2016	1/13/2016	4/18/2017	4/19/2017	6/1/2018	6/14/2018	7/20/2018	1/10/2019		1/11/2019
Colusa	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018		5/9/2018	3/28/2019	4/25/2019	4/30/2019
Contra Costa	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/5/2018	1/24/2018	12/31/2018	1/7/2019	1/22/2019
Del Norte	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018		2/26/2018	12/31/2018		1/2/2019
El Dorado	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/5/2018	1/24/2018	12/28/2018	1/3/2019	1/25/2019
Fresno	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	1/8/2018	5/7/2018	12/28/2018	1/2/2019	1/2/2019
Glenn	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018		2/22/2018	12/31/2018	1/7/2019	2/11/2019
Humboldt	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	1/3/2018	4/25/2018	12/20/2018	12/21/2018	1/2/2019
Imperial	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017		1/9/2018	12/26/2018		1/2/2019
Inyo	2/24/2016	2/24/2016	5/9/2017	5/9/2017	7/6/2018		7/9/2018	3/19/2019	3/20/2019	3/22/2019
Kern	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018		2/7/2018	1/4/2019		1/7/2019
Kings	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018		1/29/2018	1/31/2019	2/4/2019	2/11/2019
Lake	7/25/2018	7/26/2018	7/25/2018	7/26/2018	9/12/2018	9/12/2018	7/2/2019	7/12/2019		7/16/2019
Lassen	9/21/2016	9/29/2016	5/18/2017	5/25/2017	5/14/2018	5/16/2018	7/23/2018	1/8/2019	1/14/2019	1/31/2019
Los Angeles	4/20/2017	4/21/2017	1/31/2018	2/1/2018	6/29/2018	7/2/2018	7/20/2018	12/31/2018	1/14/2019	1/29/2019
Madera	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	7/26/2018	12/31/2018	1/7/2019	2/4/2019
Marin	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018		2/1/2018	12/21/2018	12/21/2018	12/21/2018
Mariposa	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018		3/14/2018	12/20/2018	1/3/2019	1/31/2019
Mendocino	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018		4/30/2018	12/31/2018		1/3/2019
Merced	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018		2/1/2018	12/21/2018	12/21/2018	12/31/2018
Modoc	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018		4/23/2018	1/16/2019	1/16/2019	1/24/2019
Mono	3/30/2016	4/6/2016	4/25/2017	6/20/2017	5/18/2018	5/22/2018	6/13/2018	12/28/2018	1/3/2019	1/17/2019
Monterey	3/29/2018	4/23/2018	10/4/2018	10/4/2018	10/4/2018		10/4/2018	3/5/2019	3/6/2019	9/4/2019
Napa	8/18/2017	8/25/2017	11/9/2017	11/13/2017	5/15/2018		5/15/2018	12/28/2018	1/2/2019	1/4/2019
Nevada	6/21/2018	6/21/2018	7/20/2018	7/25/2018	8/13/2018		8/13/2018	12/21/2018		12/21/2018
Orange	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017	1/17/2018	1/25/2018	12/28/2018	1/2/2019	1/31/2019
Placer	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		1/23/2018	1/18/2019		1/22/2019
Plumas	6/8/2017	6/23/2017	3/27/2018	3/28/2018	10/8/2018		10/15/2018			
Riverside	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/29/2019
Sacramento	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018	1/2/2019	1/2/2019
San Benito	10/24/2016	3/8/2016	9/8/2017	9/12/2017	9/25/2018		9/27/2018	3/8/2019	3/8/2019	3/18/2019
San Bernardino	5/19/2016	5/19/2016	5/1/2017	5/1/2017	6/29/2018		7/2/2018	12/31/2018		1/2/2019
San Diego	12/18/2015	5/26/2017	5/26/2017	5/26/2017	5/11/2018		6/11/2018	12/26/2018		1/15/2019
San Francisco	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018		3/27/2018	12/31/2018	1/3/2019	1/30/2019
San Joaquin	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/7/2019
San Luis Obispo	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018		2/16/2018	12/14/2018	12/18/2018	12/28/2018
San Mateo	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018		4/30/2018	12/31/2018		1/2/2019
Santa Barbara	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/22/2018	1/25/2018	12/21/2018	1/3/2019	1/14/2019
Santa Clara	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018		4/23/2018	12/27/2018		1/2/2019
Santa Cruz	4/5/2018	4/9/2018	7/19/2018	7/20/2018	8/15/2018		8/16/2018	12/31/2018	1/3/2019	1/7/2019
Shasta	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018		4/23/2018	12/13/2018	12/17/2018	1/2/2019
Sierra	10/17/2016	10/17/2016	8/16/2017	5/25/2018	6/28/2018	6/28/2018	7/23/2018	12/28/2018		1/2/2019
Siskiyou	6/30/2017	7/10/2017	6/30/2017	7/10/2017	7/27/2018		1/15/2019	9/3/2019	9/3/2019	
Solano	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017	1/23/2018	1/25/2018	12/31/2018	1/3/2019	2/21/2019
Sonoma	4/10/2017	4/10/2017	6/26/2017	6/27/2017	7/13/2018		7/23/2018	1/16/2019	1/29/2019	2/1/2019
Stanislaus	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018		4/30/2018	12/26/2018		1/3/2019
Sutter-Yuba	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018	1/7/2019	1/28/2019	1/31/2019
Tehama	4/29/2016	5/11/2017	5/8/2017	5/16/2017	7/25/2018		7/26/2018	6/20/2019		8/12/2019
Tri-City	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	1/24/2018	2/15/2018	12/31/2018	1/3/2019	1/30/2019
Trinity	9/19/2016	9/23/2016	7/14/2017	7/14/2017	6/29/2018		7/2/2018	1/30/2019		2/7/2019
Tulare	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/22/2018	1/25/2018	12/19/2018	12/21/2018	12/26/2018
Tuolumne	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018		3/1/2018	12/11/2018	12/12/2018	12/12/2018
Ventura	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018		5/25/2018	12/20/2018		12/21/2018
Yolo	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018		3/26/2018	1/30/2019	1/31/2019	1/31/2019
Total	59	59	59	59	59		59	58	38	57

* FY 2005-06 through FY 2013-14, all Counties are current

Current Through: 09/12/2019

2019 Legislative Report to the Commission
As of September 12, 2019

SPONSORED LEGISLATION

Senate Bill 10 (Beall)
Title: Mental health services: peer support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program.

Status/Location: 9/6/19 Ordered to special consent calendar. Assembly amendments concurred in. (Ayes 39. Noes 0.) Ordered to engrossing and enrolling.

Co-Sponsors: Steinberg Institute

Senate Bill 11 (Beall)
Title: Health care coverage: mental health parity.

Summary: Would require the Department of Managed Health Care and the Department of Insurance annually to report to the Legislature the information obtained through activities taken to enforce state and federal mental health parity laws.

Status/Location: 5/17/19 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/13/2019) (May be acted upon Jan 2020).

Co-Sponsors: The Kennedy Forum; Steinberg Institute

Senate Bill 12 (Beall)
Title: Mental health services: youth.

Summary: This bill would require the commission, contingent on appropriation, to administer an Integrated Youth Mental Health Program for purposes of establishing local centers to provide integrated youth mental health services, as specified. The bill would authorize the commission to establish the core components of the program, subject to specified criteria, and would require the commission to develop the selection criteria and process for awarding funding to local entities for these purposes.

Status/Location: 8/30/19 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 6/26/2019)(May be acted upon Jan 2020).

SPONSORED LEGISLATION

Assembly Bill 46 (Carrillo)

Title: Individuals with mental illness: change of term.

Summary: Current law refers to an insane or mentally defective person in provisions relating to, among other things, criminal proceedings, correctional facilities, and property tax exemptions. This bill would state the intent of the Legislature to enact legislation to replace derogatory terms, including, but not limited to, "insane" and "mentally defective," with more culturally sensitive terms when referring to individuals with mental illness.

Status/Location: 6/26/19 Approved by the Governor. Chaptered by Secretary of State - Chapter 9, Statutes of 2019.

Co-Sponsors: Disability Rights California

SUPPORTED LEGISLATION

Senate Bill 66 (Atkins)

Title: Medi-Cal: federally qualified health center and rural health clinic services.

Summary: This bill will facilitate the ability to transition patients from primary care to an onsite mental health specialist on the same day, to ensure that a patient receives needed care and follows through with treatment. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit.

Status/Location: 9/11/19 Ordered to inactive file on request of Assembly Member Calderon.

Senate Bill 582 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, when making grant funds available on and after July 1, 2021, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients.

Status/Location: 8/30/19 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 8/14/2019)(May be acted upon Jan 2020).

SUPPORTED LEGISLATION

Senate Bill 604 (Bates)

Title: Mental Health Services Act: centers of excellence.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish one or more centers of excellence to provide counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act. In implementing these provisions, the bill would require the commission to determine the areas of focus for the centers of excellence, including, but not limited to, the areas of service delivery that need improvement.

Status/Location: 5/16/19 May 16 hearing: Held in committee and under submission.

Assembly Bill 43 (Gloria)

Title: Mental health.

Summary: This bill would require the commission, in consultation with specified state, local, and private entities, to develop a strategy for the collection, organization, and public reporting of information on mental health funding, mental health programs, services, and strategies, funded by the Mental Health Services Act or other sources, and mental health outcomes, as specified. By authorizing a new use of MHSA moneys, this bill would amend the act. The bill would require the commission to make the information available as prescribed to the public and policymakers. The bill would authorize the commission, subject to available funding, to develop an innovation challenge and utilize one or more hackathons, open coding initiatives, or other approaches to an effective strategy to collect, display, and make publicly available relevant information to support the intent of the provisions.

Status/Location: 8/30/19 In committee: Held under submission.

Assembly Bill 512 (Ting)

Title: Medi-Cal: specialty mental health services.

Summary: Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by various categories, such as race, ethnicity and immigration status.

Status/Location: 9/9/19 Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 72. Noes 4.).

SUPPORTED LEGISLATION

Assembly Bill 713 (Mullin)

Title: Early Psychosis Intervention Plus (EPI Plus) Program.

Summary: Current law establishes the Early Psychosis and Mood Disorder Detection and Intervention Fund and authorizes the commission to allocate moneys from that fund to provide competitive grants to counties or other entities to create or expand existing capacity for early psychosis and mood disorder detection and intervention services and supports. Currently, implementation of the grant program is contingent upon the deposit into the fund of at least $500,000 in nonstate funds for those purposes. This bill would delete the prohibition on General Fund moneys being appropriated for purposes of those provisions and would delete the requirement that the minimum $500,000 deposit be from nonstate funds.

Status/Location: 7/12/19 Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/6/2019)(May be acted upon Jan 2020).

Assembly Bill 1126 (O'Donnell)

Title: Mental Health Services Oversight & Accountability Commission.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish technical assistance centers and one or more clearinghouses to support counties in addressing mental health issues of statewide concern, with a focus on school mental health and reducing unemployment and criminal justice involvement due to untreated mental health issues.

Status/Location: 5/16/19 In committee: Held under submission.

Assembly Bill 1352 (Waldron)

Title: Community mental health services: mental health boards.

Summary: The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Current law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.

Status/Location: 9/9/19 Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 79. Noes 0.).

SUPPORTED LEGISLATION

Assembly Bill 1443 (Maienschein)

Title: Mental health: technical assistance centers.

Summary: Would require, subject to available funding, the Mental Health Services Oversight and Accountability Commission to establish one or more technical assistance centers to support counties in addressing mental health issues, as determined by the commission, that are of statewide concern and establish, with stakeholder input, which mental health issues are of statewide concern. The bill would require costs incurred as a result of complying with those provisions to be paid using funds allocated to the commission from the Mental Health Services Fund. The bill would state the finding and declaration of the Legislature that this change is consistent with and furthers the intent of the act.

Status/Location: 8/30/19 In committee: Held under submission.

OPPOSED LEGISLATION

Senate Bill 665 (Umberg)

Title: Mental Health Services Fund: county jails.

Summary: Current law prohibits Mental Health Services Act (MHSA) funds from being used to pay for persons incarcerated in state prison or parolees from state prisons. The 2011 Realignment Legislation addressing public safety and related statutes, requires that certain specified felonies be punished by a term of imprisonment in a county jail, rather than the state prison, and provides for mandatory supervision, a period of suspended execution of a concluding portion of the sentence that is supervised by the county probation officer. This bill would, until January 1, 2023, authorize a county to use MHSA funds, if that use is included in the county plan, to provide services to persons who are incarcerated in a county jail or subject to mandatory supervision, except persons who are incarcerated in a county jail for a conviction of a felony unless for purposes of facilitating discharge.

Status/Location: 9/6/19 In Assembly. Read first time. Held at Desk.