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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
May 27, 2021
9:00 AM – 1:00 PM

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

Commission/Teleconference Meeting Notice

NOTICE IS HEREBY GIVEN that the Mental Health Services Oversight Accountability and Commission (the Commission) will conduct a **teleconference meeting on May 27, 2021**.

This meeting will be conducted pursuant to Governor Newsom's Executive Order N-29-20, issued March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic. Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE: May 27, 2021

TIME: 9:00 AM – 1:00 PM

ZOOM ACCESS:

Link: https://zoom.us/j/92486603658
Dial-in Number: 1-408-638-0968
Meeting ID: 924 8660 3658
Passcode: 806316

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

***The Commission is not responsible for unforeseen technical difficulties that may occur in the audio feed.**

PUBLIC PARTICIPATION PROCEDURES: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to

comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

1) Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.
2) Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.
3) Catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

Our Commitment to Transparency

Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

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

AGENDA

Lynne Ashbeck
Chair

Mara Madrigal-Weiss
Vice Chair

Commission Meeting Agenda

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

9:00 AM **Call to Order and Welcome**

Chair Lynne Ashbeck will convene the Mental Health Services Oversight and Accountability Commission meeting and make announcements.

9:20 AM **Roll Call**

Roll call will be taken.

9:25 AM **General Public Comment**

General Public Comment is reserved for items not listed on the agenda. No debate nor action by the Commission is permitted on general public comments, as the law requires formal public notice prior to any deliberation or action on agenda items.

9:55 AM **Action**

1: Approve April 22, 2021 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the April 22, 2021 teleconference meeting.

- Public Comment
- Vote

10:05 AM **Action**

2: Ventura County Innovation Plan

Presenter:

- **Hilary Carson, MSW, Senior MHSA Program Administrator, Ventura County Behavioral Health**

The Commission will consider approval of $3,080,986 in Innovation funding for Ventura County's Mobile Mental Health Innovation project.

- Public comment
- Vote

10:35 AM **Action**

3: Los Angeles County-Trieste (aka Hollywood 2.0) Innovation Project

Presenter:

- **Jonathan E. Sherin, M.D., Ph.D., Director of Mental Health, Los Angeles County**

The Commission will hear an update and will consider approving the proposed changes to the Trieste (aka Hollywood 2.0) Innovation Project.

- Public Comment
- Vote

11:35 AM **BREAK**

11:45 AM **Action**

4: Santa Clara County Innovation Plan

Presenter:

- **Jeanne Moral, Program Manager III, County of Santa Clara Behavioral Health Services, Systems Initiatives, Planning & Communication**

The Commission will consider approval of $27,949,227 in Innovation funding for Santa Clara County's Community Mobile Response Program Innovation project.

- Public comment
- Vote

12:15 PM **Action**

5: Marin County Innovation Plan

Presenter:

- **Taffy Lavié, Administrative Assistant II, County of Marin, Department of Health & Human Services, Behavioral Health & Recovery Services Division**

The Commission will consider approval of $1,795,000 in Innovation funding for Marin County's From Housing to Healing Re-Entry Community for Women Innovation project.

- Public Comment
- Vote

12:45 AM **Action**

6: Legislative Priorities for 2021

Presenters:

- **Norma Pate, Deputy Director**
- **David Stammerjohan, Chief of Staff, Office of Senator Eggman**

The Commission will consider legislative and budget priorities for the current legislative session including Senate Bill 465 (Eggman) and the Governor's May Revise.

- Public comment
- Vote

1:00 PM **Adjournment**

AGENDA ITEM 1

Action

May 27, 2021 Commission Meeting

Approve April 22, 2021 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the April 22, 2021 Commission teleconference 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) April 22, 2021 Meeting Minutes

Handouts: None.

Proposed Motion: The Commission approves the April 22, 2021 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

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

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
April 22, 2021

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

920-3349-3807; Code 723810

Members Participating:

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mayra Alvarez
Ken Berrick
John Boyd, Psy.D.
Keyondria Bunch, Ph.D.
Steve Carnevale
Shuonan Chen
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Tina Wooton

Members Absent:

Sheriff Bill Brown
Assembly Member Wendy Carrillo
Khatera Tamplen

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Brian Sala, Ph.D., Deputy Director, Research and Chief Information Officer

[Note: Agenda Item 2 was taken out of order. These minutes reflect this Agenda Item as listed on the agenda and not as taken in chronological order.]

CALL TO ORDER AND WELCOME

Chair Lynne Ashbeck called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:03 a.m. and welcomed everyone.

Chair Ashbeck welcomed Steve Carnevale and Shuonan "Shuo" Chen to the Commission. Commissioners Carnevale and Chen introduced themselves.

Chair Ashbeck reviewed the meeting protocols.

Announcements

Chair Ashbeck stated the next MHSOAC meeting is scheduled for Thursday, May 27th. The agenda will be posted on May 17th.

Chair Ashbeck asked the Committee Chairs to update the Commission on the work of the Committees:

Research and Evaluation Committee Update

Commissioner Danovitch, Chair of the Research and Evaluation Committee, provided a brief update on the activities and accomplishments of the Research and Evaluation Committee:

- The Committee held a Data Forum in March and presented the Commission's latest dashboards on fiscal transparency, programs that are supported by the Mental Health Services Act (MHSA), and disparities.
- A Subcommittee created by the Research and Evaluation Division has been developing a strategy around research and evaluation and will be meeting next month.
- The Research and Evaluation team submitted an abstract for the American Public Health Association annual meeting in October. The abstract is on a study that evaluates the service needs of Full-Service Partnership (FSP) clients who have a child in the welfare system and the impact of FSP services on parent and child reunification. The team will use data to examine the relationship between involvement in services such as FSPs and outcomes such as parent and child reunification or avoidance of criminal justice involvement.
- The Research and Evaluation team also published an article in an SAS publication on the Commission's use of data and data analytics. The data linkage work connecting different databases to make the data available and interpretable will be featured on May 18th through 20th, in an SAS global forum, a worldwide event that attracts over 25,000 professionals. Due to the COVID-19 pandemic, this event will be held remotely.

CLCC Update

Commissioner Alvarez, Chair of the Cultural and Linguistic Competency Committee (CLCC), provided a brief update on the activities and accomplishments of the CLCC:

- The CLCC met for the second time on April 12th as a continuation of the first meeting which was held in March.
- The second meeting consisted of additional discussion on the Solano County Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Innovation Project. This model was presented at a previous Commission meeting and demonstrated the effectiveness in reaching Filipino-American, Latino, and LGBTQ communities in Solano County. The Committee had an opportunity to hear more about the collaborative and to identify opportunities to expand that approach to report back to the Commission.
- The Committee provided input on the importance of community leadership in program implementation, recognizing that the voices of the most impacted individuals must be at the table. The Committee discussed how to bring that to life with this project and how to ensure that lessons learned are applied to this model in additional counties.
- The Committee heard a presentation from Executive Director Ewing on the funding proposal that seeks to leverage the work of the California Reducing Disparities Project (CRDP) and its pilot projects and initiatives that are led by community-based organizations that serve communities of color and other marginalized communities. This is also a follow-up from a previous Commission meeting where the Committee was charged with identifying opportunities that exist to expand the CRDP and work in partnership with counties to address racial inequities in the mental health system.
- The Committee specifically discussed a proposal to contract with a statewide technical assistance provider that assists community-based organizations in their efforts to collaborate with local county behavioral health departments. Feedback received from the Committee was to encourage the Commission to move forward as expeditiously as possible, given the multiple crises that have impacted the mental health and well-being of communities, and to assist community organizations in building relationships with behavioral health departments to address the mental health conditions resulting from the COVID-19 pandemic as well as those that existed prior to the pandemic.
- Additional Committee meetings were added to the calendar in response to the need for important discussion on these topics. The next CLCC meeting is scheduled for May 13th.

<u>CFLC and EPI Plus Advisory Committee Updates</u>

Chair Ashbeck stated Commissioner Tamplen, Chair of the Client and Family Leadership Committee (CFLC) and the Early Psychosis Intervention Plus (EPI Plus) Advisory Committee, was unable to be in attendance. A summary of the Committees' activities is included in the meeting packet.

Roll Call

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

INFORMATION

1: Public Hearing on Prevention and Early Intervention

Presenters:

- Vilma Reyes, Psy.D., Clinical Supervisor/Associate Community Mental Health Initiative Director
- Joy D. Osofsky, Ph.D., Paul J. Ramsay, Chair of Psychiatry, and Barbara Lemann, Professor of Child Welfare, Louisiana State University Health Sciences Center
- Paula Allen, Global Leader and SVP, Research and Total Wellbeing, Morneau Shepell
- Andreea L. Seritan, M.D., Professor of Clinical Psychiatry, UCSF Department of Psychiatry and Behavioral Sciences

Chair Ashbeck stated this work is led by Vice Chair Madrigal-Weiss and Commissioner Alvarez. The Commission has been working to advance prevention and early intervention of mental health statewide. This project was initiated by Senate Bill (SB) 1004. Prior to the COVID-19 Pandemic, the Subcommittee held two in-person meetings with approximately 110 attendees and has recently completed a series of virtual events, including ten listening sessions and three forums, which engaged nearly 800 Californians from across the state. Written summaries are being produced and will be publicly disseminated for each event. Video recordings of the three forums will be available on the Commission's YouTube channel.

Chair Ashbeck stated today's hearing is the second hearing before the Commission on prevention and early intervention. The first hearing highlighted key concepts and opportunities for population-based prevention and early intervention. Today's hearing will explore key concepts and opportunities for prevention and early intervention across the lifespan and place-based approaches to prevention and early intervention to meet people where they learn, work, connect with social networks and cultural practices, and receive care and support. She asked the members of the panel to give their presentations.

Vilma Reyes, Psy.D.

Vilma Reyes, Psy.D., Clinical Supervisor/Associate Community Mental Health Initiative Director, provided an overview, with a slide presentation, of the challenges to the well-being of Latinx immigrant families with young children, including those resulting from the COVID-19 pandemic and impacts on existing or new mental health inequities; opportunities to address mental health disparities during early childhood, including addressing risk factors and promoting protective factors experienced by members of

diverse communities; and policies and practices that should be prioritized by the state to promote well-being among parents and their children up to age five.

Dr. Reyes stated trauma extends beyond life experiences that have caused adversity and harm to individuals and families to the systems that are not questioned and the adverse childhood experiences (ACEs) that are not assessed, but these things make huge impacts in the development of individuals. The majority of harm being presented to the mental health systems support was either caused, exacerbated, or maintained because of structural racism and other structural traumas. This leads children to believe they are fundamentally unsafe. Messages over time from the early years of unsafety cause a loss of the sense of control, connection, and meaning. This can be changed but the source of healing must be embedded in the outer layer. It is important to create healing systems and to put trauma-reducing practices into place that are safe, supportive, and healing.

Joy D. Osofsky, Ph.D.

Joy D. Osofsky, Ph.D., Ramsay Chair of Psychiatry and Lemann Professor of Child Welfare, Louisiana State University Health Sciences Center, provided an overview, with a slide presentation, of the impacts of the COVID-19 pandemic on children, adolescents, and schools. She stated COVID-19 differs from other disasters because of the social anxiety and indefinite uncertainty it has caused. She stated the importance of routines and structure, concentrating on things that can be controlled, and incorporating ways to stay healthy and to relate to other students safely in school settings as ways to support the emotional and mental health needs of students as they return to school. She stated structure and predictability is important to support resilience in children during these times of indefinite uncertainty.

Dr. Osofsky stated her organization revised their list of Ten Considerations for Mental Health Professionals Helping in Schools Following Disasters to relate to the COVID-19 pandemic. The ten considerations, which were not included in her original presentation materials, are as follows:

1. Remember that the entire school community and their families have been impacted by the COVID-19 pandemic – school administrators, teachers, staff, support personnel, and students.
2. Recognize that each school has its own culture. It is important to learn the culture of the school as well as the community.
3. Is the school facility adequately prepared to institute the necessary structural and physical precautions that are needed for safety?
4. The way you start a relationship with a school system will set the tone for your work.
5. For mental health professionals or counselors, define your role in the school before providing services, and determine if your organization has an agreement and what your role will be with the school district – this will impact how referrals and confidentiality are handled.

6. Work with the school system to identify what their needs are following COVID-19.
7. It is important to be flexible when working in schools.
8. It may be helpful to talk to additional staff at the school.
9. With COVID-19, like other major disasters, it is important to recognize that everyone has been impacted in some way.
10. Parents and caregivers are always important.

Paula Allen

Paula Allen, Global Leader and Senior Vice President, Research and Total Wellbeing, Morneau Shepell, provided an overview, with a slide presentation, of workplace mental health, the Mental Health Index (MHI), which offers a clear measure of mental health in working populations over time, and the social determinants of mental health that the workplace can influence, such as access to health care, income equality, and job security. She stated mental health is the most important core factor in overall well-being and is a collective responsibility. It impacts virtually everything – quality of life, productivity at work, and, ultimately, how successful their organizations can be based on their contribution.

Ms. Allen stated the MHI shows that mental health of working Americans declined since the COVID-19 pandemic and continues to be strained. She noted that the mental health score for managers is lower than it is for non-managers. She stated employees with better employer support have better MHI scores. She stated the importance of prioritizing employee well-being in the workplace. The Sustainability Accounting Standards Board (SASB) is one of many working toward adding mental health to environmental, social, and governance (ESG) frameworks.

Ms. Allen stated workplace mental health and everything organizations can do to be helpful are not onerous. Those things such as empathy, training, and resources help make a meaningful difference in the lives of their employees, and in turn make a meaningful difference in the economy. Those things just need to be done. A major barrier is the lack of knowledge in most organizations of how critically important this is and how simple it can be integrated into business plans. This is the work that needs to be done.

Andreea L. Seritan, M.D.

Andreea L. Seritan, M.D., Professor of Clinical Psychiatry, UCSF Department of Psychiatry and Behavioral Sciences, provided an overview, with a slide presentation, of the impacts of the COVID-19 pandemic on the mental health of older adults, opportunities for prevention and early intervention within older adult populations and strategic settings for interventions, and policies and practices that should be prioritized by the state to promote prevention and early intervention in mental health among older adults. She suggested the continued use of telepsychiatry beyond the COVID-19 pandemic, screening using tools validated with diverse populations, increased access to mental health care services, and better reimbursement of services provided with an

interpreter. She stated all health care providers should be trained to care for older adults. It is important to find solutions now and not to wait for the next crisis.

Commissioner Questions and Discussion

Vice Chair Madrigal-Weiss acknowledged importance of not just training but intentional, systemic, trauma-informed tools and practices in schools. She stated that students have said their first priority is an emotional safe place, and schools should be responsive to that need.

Commissioner Alvarez highlighted the importance of thinking beyond traditional definitions of what Prevention and Early Intervention can be to better meet the needs of our communities in the settings where they are, whether it is the workplace, schools, or homes. She acknowledged the unique opportunity to reform the mental health system to be more responsive to communities when updating the PEI regulations.

Commissioner Berrick stated that the information presented can be used develop a roadmap and action plan to support young people and adults in the coming months.

Commissioner Wooton acknowledged the importance of workplace mental health and having a diverse workforce to meet the needs of communities. She highlighted the work that social workers and first responders take on every day, and the value of making employees feel safe.

Public Comment

Jesus Sanchez, Co-Founder and Executive Director, Gente Organizada, spoke about how restrictive prevention and early intervention regulations are on communities. The speaker stated their organization works with a youth group that advocates for mental health services and stigma reduction. In local efforts, they have been frustrated at the lack of responsiveness and investments in youth and that prevention and early intervention funds are inaccessible, which compounds existing inequities in communities and sends thousands of youths into the criminal justice system without giving most of them an opportunity to address their challenges and trauma. Easing restrictions can save lives and empower service providers to be responsive to the community. The speaker suggested centering investment in children and youth with non-traditional approaches and school-based mental health as strategies to achieve prevention and early intervention.

Jesus Sanchez stated several individuals from their organization tried to participate in this meeting and make public comment but had to log off. The speaker asked the Commission to allow these individuals to provide their public comment via email.

Josue Garcia-Minjares, Student, Cal Poly Pomona, and Member of a Pomona social action group, spoke about how restrictive prevention and early intervention regulations impact lives in Pomona. The speaker shared their story of living with major depressive disorder and the impacts it has on their ability to perform in society. The speaker stated they have dedicated their life to advocating for mental health resources and sharing resources to their community in the form of conferences, workshops, and healing circles.

Josue Garcia-Minjares stated one way for individuals to receive help earlier is if local mental health institutions have more freedom to spend their prevention and early intervention funds on timely and responsive investments. The speaker urged the Commission to ease PEI funding regulations to address issues before they get out of control, which will save individuals' futures and help them get back on track and lead productive lives.

Steve Leoni, consumer and advocate, stated recovery largely requires the elements being discussed today. The speaker agreed with Dr. Reyes that the sense of control, connection, and meaning and bringing intentionality and mindfulness to problems is central. The speaker stated they also agreed with the point that individuals heal through relationships, which is part of the issue behind peer certification. The speaker suggested that the Commission find a way, while pursuing the work on evaluation and building the database, to measure how well programs and counties are doing in fostering relationships. The speaker suggested sharing the information presented during the panel discussion with legislators.

Carol Sewell, California Commission on Aging, stated the issue of older adult mental health is often overlooked. The speaker asked the Commission to make time at a future meeting for Dr. Seritan to more fully present her material. The older adult population is dependent upon the outreach of community-based organizations. The speaker stated the need for strong connections between the mental health network and the area agencies on aging and the aging and disability resource connections in California. There needs to be a community focus on making that happen. The older adult population needs to remain an important component of the prevention and early intervention outreach.

Mark Karmatz, consumer and advocate, asked how peer workers are being supported in the older adult and school populations.

BREAK

[Note: Agenda Item 2 was taken out of order and was heard after Agenda Item 3.]

ACTION

2: <u>Award Early Psychosis Intervention Plus (EPI Plus) Phase 2 Grants</u>

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants

Chair Ashbeck stated the Commission will consider awarding EPI Plus Grants to the highest scoring applications received in response to the Request for Applications for the Early Psychosis Intervention Plus Phase 2 Grants. She asked staff to present this agenda item.

Tom Orrock, Chief of Stakeholder Engagement and Grants, provided an overview, with a slide presentation, of the challenge of available services for early psychosis, Assembly Bill (AB) 1315, timeline, goals, and evaluation of the EPI Plus Program Phase 2 Grants. He announced the applicants with the highest overall scores as follows:

New or Existing Program Category

- Santa Clara County

Hub and Spoke Program Category

- Nevada County

Mr. Orrock stated staff has emailed summaries of these programs to Commissioners and will also post them on the Commission website.

Commissioner Questions and Discussion

Chair Ashbeck asked for a motion to approve the EPI Plus Phase 2 Grant awards.

Vice Chair Madrigal-Weiss moved the staff recommendation.

Commissioner Boyd seconded.

Public Comment

Richard Gallo, Volunteer ACCESS Ambassador, spoke in support of the EPI Plus Phase 2 Grant awards.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of the EPI Plus Phase 2 Grant awards.

Action: Vice Chair Madrigal-Weiss made a motion, seconded by Commissioner Boyd, that:

For each of the grants, the Commission authorizes the Executive Director to:

- *Issue a Notice of Intent to Award EPI Plus Grants to the two highest scoring applicants in each category:*

  Santa Clara County – New or Existing and

  Nevada County – Hub and Spoke

- *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 Applications.*
- *Execute the contracts upon expiration of the protest period or consideration of protests, whichever comes first.*

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

The following Commissioners voted “Yes”: Commissioners Berrick, Boyd, Carnevale, Chen, Gordon, Mitchell, and Wooton, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

ACTION

3: Fresno County Innovation Plans

Presenter:

- Ahmad Bahrami, MBA, Division Manager-Public Behavioral Health/Equity Services Manager, Fresno County Department of Behavioral Health

Chair Ashbeck recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy. She asked Vice Chair Madrigal-Weiss to facilitate this agenda item.

Vice Chair Madrigal-Weiss stated the Commission will consider approval of $1,000,000 in Innovation funding for Fresno County's Suicide Prevention Follow-Up Call Program Innovation Project and $2,400,000 for their California Reducing Disparities Project (CRDP) Evolutions Innovation Project. She asked the county representative to present this agenda item.

Ahmad Bahrami, MBA, Division Manager-Public Behavioral Health/Equity Services Manager, Fresno County Department of Behavioral Health, provided an overview, with a slide presentation, of the need, proposed project to address the need, and budget of the proposed CRDP Project Evolutions Innovation Project. He stated the county is seeking to fund the three CRDP projects at their current level as part of the sustainability approach.

Mr. Bahrami continued the slide presentation and discussed the need, proposed project to address the need, and budget of the proposed Suicide Prevention Follow-Up Call Program Innovation Project. He stated the county plans to adapt the Follow-Up Call program model in a way that may help better inform suicide prevention activities and interventions in the future.

Commissioner Questions and Discussion

Vice Chair Madrigal-Weiss asked for a motion to approve Fresno County's CRDP Evolutions Innovation Project.

Commissioner Gordon moved the staff recommendation.

Commissioner Wooton seconded.

Public Comment

Stacie Hiramoto spoke in support of the proposed Fresno County Innovation Project.

Julie Snyder, Steinberg Institute, spoke in support of the proposed Fresno County Innovation Project.

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

The Commission approves Fresno County's Innovation Plan as presented as follows:

Name: California Reducing Disparities Project Evolutions

Amount: Up to $2,400,000 in MHSA Innovation funds

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Berrick, Boyd, Carnevale, Chen, Gordon, Mitchell, and Wooton, and Vice Chair Madrigal-Weiss.

Vice Chair Madrigal-Weiss asked for a motion to approve Fresno County's Suicide Prevention Follow-Up Call Program Innovation Project.

Commissioner Wooton moved the staff recommendation.

Commissioner Berrick seconded.

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

The Commission approves Fresno County's Innovation Plan as presented as follows:

Name: Suicide Prevention Follow-Up Call Program

Amount: Up to $1,000,000 in MHSA Innovation funds

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Berrick, Boyd, Carnevale, Chen, Gordon, Mitchell, and Wooton, and Vice Chair Madrigal-Weiss.

Chair Ashbeck rejoined the meeting.

ACTION

4: <u>Approve March 25, 2021, MHSOAC Meeting Minutes</u>

Chair Ashbeck stated the Commission will consider approval of the minutes from the March 25, 2021, teleconference meeting.

Chair Ashbeck asked for a motion for approval of the minutes.

Vice Chair Madrigal-Weiss made a motion to approve the March 25, 2021, teleconference meeting minutes.

Commissioner Berrick seconded.

Public Comment

No members of the public addressed the Commission.

Action: Vice Chair Madrigal-Weiss made a motion, seconded by Commissioner Berrick, that:

- *The Commission approves the March 25, 2021, Teleconference 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 Berrick, Boyd, Gordon, Mitchell, and Wooton, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

The following Commissioners abstained: Commissioners Carnevale and Chen.

GENERAL PUBLIC COMMENT

Richard Gallo stated the Santa Cruz County Mental Health Advisory Board met last Thursday and the administrators claimed that the county will receive a decrease in MHSA funding. The speaker stated the Department of Health Care Services (DHCS) website does not address this topic. The speaker asked for more information on future MHSA funding to counties.

Chair Ashbeck asked staff to respond to Richard Gallo’s question.

Executive Director Ewing stated there are factors that make it difficult to answer this question. One of these is that the Department of Finance has issued information that suggests it must reconcile prior year allocations. There is as much as a $100 million reduction in MHSA funds going to counties in prior fiscal years. This happens because the state projects the amount of funding available in a given fiscal year and the reconciliation process takes some time. This means that counties will need to make adjustments in terms of the amount of funding that is currently available based on the need to reimburse the state, depending on how their allocation was given to them over time and whether or not it was spent during the fiscal year in question.

Executive Director Ewing stated, at the same time, the economy is currently making it difficult to forecast the MHSA revenues that will be available in future years. The January revenue projection from the Department of Finance shows an increase of approximately $100 million from the current fiscal year to the new fiscal year, and new projections will come out within the next 60 days from the Department of Finance on what can be expected.

Stacie Hiramoto welcomed the new Commissions and stated REMHDCO looks forward to working with them.

Stacie Hiramoto asked the Commission to take up SB 106, Mental Health Service Act: innovative programs, which is of great concern to the mental health community at large at the state level. The speaker requested putting this bill on the agenda for discussion at the next Commission meeting.

Theresa Comstock, Executive Director, California Association of Behavioral Health Board and Commissions (CALBHB/C), asked the Commission to consider augmenting the MHSOAC Stakeholder Advocacy Contracts budget to include an additional amount specifically for stakeholders who serve as members of boards and commissions. The speaker stated current expenditures related to the contract with the MHSOAC total over

$115,000 but the contract is at $55,500. The speaker stated a letter with their full comment has been sent to Chair Ashbeck and staff.

ADJOURNMENT

There being no further business, the meeting was adjourned at 12:35 p.m.

AGENDA ITEM 2

Action

May 27, 2021 Commission Meeting

Ventura County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Ventura County's request to fund the following new Innovative project:

1. **Mobile Mental Health**

Ventura County is requesting up to $3,080,986 of Innovation spending authority over four years to establish a mobile mental health program, which will serve as a way to reach out to otherwise disenfranchised persons and communities, reduce stigma and increase access to mental health services. Ventura County is proposing to obtain, staff and utilize a mobile mental health van for bringing services to three distinct populations and provide healthcare services.

The proposed project will serve:

- as a service "center" for **homeless mentally ill** who may not have access to or seek mental health services,

- as an augmentation to mobile crisis teams **and for those who may be engaged with a person who does not meet the necessity criteria for intervention and can be accommodated at home, or who has timed out of an ER psychiatric hold**, and

- as a "pop-up" clinic for **persons and cultural communities who might otherwise feel repercussions/stigma from walking into a mental health brick and mortar clinic**.

The County's 2019 Community Needs Assessment reports that there has been a continuous need for additional mental health services, access to mental health professionals and included the following critical areas of need:

1. Enhanced services for individuals who are homeless with mental illness,
2. Access to culturally responsive mental health services,
3. Augmentation of crisis team services.

The County indicates that they have tried to configure a program that provides a combination of services that would match these identified needs through funding Crisis Intervention Training for first responders, Primary Care Intervention Services and two Triage Grants. The concerns above remain, and are continually raised by their community through feedback, surveys, and provider assessments.

The County is proposing to purchase, modify and staff a van that will provide "flexible, direct health and mental health care to un- and under- served persons regardless of insurance or legal status". (Page 6)

The van will operate 8 hours per day, Tuesday through Saturday. The team in the van will be comprised of bicultural and bilingual staff, including peers at all levels. Because the van will utilize more of a neighborhood approach, the County feels it will be less stigmatizing than traditional clinics.

Ultimately the County hopes to learn if this is an effective method of delivering mental health services to these populations and should this type of service (mobile mental health vans) be increased or if one target population is utilizing these services more effectively than another.

This plan was shared with Community members, including stakeholders and Board of Supervisors, and Behavioral Health Advisory Board members at meetings on March 10, March 15, April 1, and April 19, 2021. Their 30-day public comment period was from March 15, 2021 to April 19, 2021. The County reports that all the feedback was positive with only one question about days the van would be in service. The response was that these intended days are to accommodate M-F workdays as well as the hours of operation (10A-7P) to allow for "after workday" accommodations.

Commission staff originally shared this project with its six stakeholder contractors, the listserv, and two Commission committee (CFLC and CLCC) on March 16, 2021 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared on April 28, 2021. No comments were received in response to Commission sharing the final plan with stakeholder contractors, the listserv, and committees.

Enclosures (2): (1) Biography for Ventura County's Innovation Presenter; (2) Staff Analysis: Mobile Mental Health

Handout (1): PowerPoint Presentation: Mobile Mental Health

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

Mobile Mental Health:
https://mhsoac.ca.gov/sites/default/files/Ventura_INN_Mobile%20Health.pdf

Proposed Motion: The Commission approves Ventura County's Innovation plan, as follows:

Name: Mobile Mental Health

Amount: Up to $3,080,986 in MHSA Innovation funds

Project Length: Four (4) Years

Hilary Carson, MSW
Senior MHSA Program Administrator
Ventura County Behavioral Health

Hilary received her MSW from NYU and has worked with nonprofit organizations specializing in services for families involved in the criminal justice system. She has background in program and evaluation design. She joined Ventura County Behavioral Health in June 2016 and has overseen several Innovation projects from their inception through their fruition and final report.

STAFF ANALYSIS—VENTURA COUNTY

Innovation (INN) Project Name:	**Mobile Mental Health**
Total INN Funding Requested:	**$3,080,986**
Duration of INN Project:	**4 Years**
MHSOAC consideration of INN Project:	**May 27, 2021**

Review History:

Approved by the County Board of Supervisors:	May 11, 2021
Mental Health Board Hearing:	April 19, 2021
Public Comment Period:	March 15, 2021 to April 19, 2021
County submitted INN Project:	April 26, 2021
Date Project Shared with Stakeholders:	March 17, 2021 and April 28, 2021

Project Introduction:

Ventura County is requesting up to $3,080,986 of Innovation spending authority to establish a mobile mental health program, which will serve as a way to reach out to otherwise disenfranchised persons and communities, reduce stigma and increase access to mental health services. Ventura County is proposing to obtain, staff and utilize a mobile mental health van for bringing services to three distinct populations (see bulleted section below) and provide healthcare services.

The proposed project will serve:

- as a service "center" for **homeless mentally ill** who may not have access to or seek mental health services,
- as an augmentation to mobile crisis teams **and for those who may be engaged with a person who does not meet the necessity criteria for intervention and can be accommodated at home, or who has timed out of an ER psychiatric hold**, and
- as a "pop-up" clinic for **persons and cultural communities who might otherwise feel repercussions/stigma from walking into a mental health brick and mortar clinic**.

What is the Problem?

The County reports that there has been a continuous need for additional mental health services and access to mental health professionals as evidenced in their 2019 community needs assessments and stakeholder communications.

Critical areas of concern are:

1. Enhanced services for individuals who are homeless with mental illness,
2. Access to culturally responsive mental health services,
3. Augmentation of crisis team services.

The County indicates that they have tried to configure a program that provides a combination of services that would match these identified needs through funding Crisis Intervention Training for first responders, Primary Care Intervention Services and two Triage Grants. The concerns above are continually raised by their community through feedback, surveys, and provider assessments.

The County is currently providing services through One Stop mental health programs, Whole Person Care Programs, Logrando Bienstar, the Farmworker partnership program, Healing the Soul, outreach programs to Latinx and Mixteco populations and Crisis intervention, and MHSA funded Prevention and Early Intervention programs. ***Despite these efforts, the County reports that the community feedback continues to identify ongoing needs and culturally appropriate services. (See page 4 of Innovation proposals for graph of Community Needs Assessment Findings).***

Further, the cultural and geographic diversity of the county combined with the effects of barriers such as transportation, insurance and legal status, “intimidation” by health care settings (Page 5), hours of operation, etc. had created a need for the County to provide more appropriate access to services.

The county may wish to identify any data (numbers of unserved or served persons) in these populations and/or data it has on increased need for services.

How this Innovation project addresses this problem:

The County is proposing to purchase, modify and staff a van that will provide “flexible, direct health and mental health care to un- and under- served persons regardless of insurance or legal status”. (Page 6)

The County reports that its 2019-2020 crisis response data does not support the need for a full-time van (Page 7) for this one purpose and so by combining other elements of need (medication, support, health care follow up), this mobile mental health van will provide field-based services to and populations who might not have been served previously.

The van will operate 8 hours per day, Tuesday through Saturday. The team in the van will be comprised of bicultural and bilingual staff, including peers at all levels. Because

the van will utilize more of a neighborhood approach, the County feels it will be less stigmatizing than traditional clinics.

Community Program Planning Process (Pages 12-13)

Local Level

The County reports that the CPP process was conducted over the course of two years and the countywide needs assessment portion of this process coincided with and is included in its Three-Year Program and Expenditure Plan Report.

The County advertised for ideas for an innovation with its prioritized populations—Latinx, Black and African American, LGBTQIA, Homeless, people with dual diagnoses and people at risk of suicide. A planning committee was then formed which included these populations as well as with all other community stakeholders, (education, law enforcement, religious communities, and CBOs). Twenty-eight ideas were submitted through this "advertisement" (see Page 13 for announcement) and these were assessed by the planning committee and their top three were reviewed and Mobile Mental Health was the number one choice.

This plan was shared with Community members, including stakeholders and Board of Supervisors, and Behavioral Health Advisory Board members at meetings on March 10, March 15, April 1, and April 19, 2021. Their thirty (30) public comment period was from March 15, 2021 to April 19, 2021The County reports that all the feedback was positive with only one question about days the van would be in service. The response was that these intended days are to accommodate M-F workdays as well as the hours of operation (10A-7P) to allow for "after workday" accommodations.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors, the listserv, and two Commission committee (CFLC and CLCC) on March 16, 2021 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared with stakeholders on April 28, 2021.

No comments were received in response to Commission sharing the plan with stakeholder contractors, the listserv, and committees.

Learning Objectives and Evaluation:

The learning questions the County would like to address are:

- Does the provision of mobile services provide improved access to homeless persons or temporary or year-round farmworkers?
- What were the reasons people came to this mobile unit and were they satisfied?
- Which services were most utilized?
- How were the health care services utilized?

Evaluation and positive indicators for these objectives will include:

- Increased first time clients.
- more consistent engagement of SMI with treatment
- responses from focus groups (8-10 participants
- client satisfaction rate of 80% or higher
- number of services which are reimbursable (for program solvency)
- data regarding capacity in any target area
- does usage validate acquisition of another van?
- successful treatments and referrals to other clinical services

Ultimately the County hopes to learn if this is an effective method of delivering mental health services to these populations and should this type of service (mobile mental health vans) be increased or if one target population is utilizing these services more effectively than another.

The county may wish to identify any baseline data (co-morbidity, satisfaction surveys, suicidal rates) it has for any of these populations. Further, the County may wish to identify the numbers of anticipated persons/services it expects to deliver over the course of this Innovation.

The Budget

4 Year Budget	FY 21/22	FY 22/23	FY 23/24	FY 24/25		Total
Personnel	$ -	$ -	$ -	$ -		$ -
Direct Costs - Contractor	$ -	$854,874	$879,462	$905,980		$ 2,640,316.00
Indirect Costs - Contractor	.	$72,974	$75,163	$77,418		$ 225,555.00
Indirect Costs - County		$111,134	$113,357	$115,624		$ 340,115.00
Non-recurring Costs	$ 175,000.00	$ -	$ -			$ 175,000.00
Total Proposed Expenditures	$ 175,000.00	$ 111,134.00	$ 113,357.00	$ 115,624.00		$ 3,380,986.00
Funding Source	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
Innovation Funds	$175,000	$938,982	$967,982	$999,022		$3,080,986.00
Medi-Cal FFP	$ -	$ 100,000.00	$ 100,000.00	$ 100,000.00		$ 300,000.00
1991 Realignment						$ -
Behavioral Health Subaccount						$ -
Any other funding						$ -
Total Proposed Expenditures	$ 175,000.00	$1,038,982	$ 1,067,982.00	$ 1,099,022.00	$ -	$ 3,380,986.00

The County is requesting authorization to spend up to $3,080,986 in MHSA Innovation funding for this project over a period of four (4) years. The County is also estimating that it will bill for and use $300,000 of FFP for this project. The total project costs are estimated at $3,380,986.

According to the County's Chief Financial Officer, all costs, except county administration and purchase of the van (totaling $563,245), are for the contractor to pay for the costs related to the implementation of the plan:

Personnel costs, including benefits, have been factored into direct and indirect costs, paid for by the Contractor in the amount of $2,817,741 (83.3% of the total project):

- .5 FTE Program Director,
- 1.0 FTE Mental Health Nurse,
- 1.0 FTE for a Clinician,
- 2.0 FTE for Mental Health Associate/Peers,
- 1.0 FTE Office Assistant,
- Psychiatrist (at .125 FTE),
- Evaluation
- Vehicle maintenance,
- Staff training,
- Supplies, including computers and web page advertising.

Ventura County will pay for overhead costs ($388,245) along with the purchase of a van ($175,000) in the amount of $563,245 representing 16.7% of the total project budget.

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

AGENDA ITEM 3

Action

May 27, 2021 Commission Meeting

Los Angeles County Innovation Plan Change Request

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Los Angeles County's request to change the True Recovery Innovation Embraces Systems that Empower (TRIESTE) Innovation project previously approved by the Commission in 2019. The project has not yet been started.

Project Background: The Original Innovation Project

On May 23, 2019, the Commission approved Los Angeles County's TRIESTE Innovation project for five years with an Innovation budget of up to $116,750,000.

The goal of the TRIESTE project was to test whether shifting an entire population, within a geographic boundary, to a recovery-informed mental health system would result in increased access to mental health services and an increase in the quality of those services thus improving outcomes without increasing current costs.

Los Angeles County's original TRIESTE Innovation project plan stated that although the spirit of the MHSA is recovery-informed, two significant barriers prevent the shift to a recovery-informed system:

1. Compliance with the Medicaid-based fee-for-service payment system and its copious associated regulatory processes (ex. Documentation) that are intended to ensure accountability, and
2. An over-emphasis on the treatment and mitigation of the symptoms of the illness rather than on the well-being of people served and their re-integration into the community at large.

The County's TRIESTE Innovation project focused on the Hollywood region as the test area and planned to temporarily replace the existing funding structure and requirements for mental health services with a recovery-informed system funded 100% with Innovation dollars.

The County proposed to fund the TRIESTE Innovation project solely with Innovation funds to allow for maximum flexibility to create a comprehensive, recovery-informed mental health system through "well-being-focused" services including a health home for every person in need of care. Services were to be appropriate to each member's level of care needs, focused on addressing both physical and mental healthcare where psychosocial services are the primary focus and clinical services would move to a support role. Health homes may be a full-service partnership, a wellness and peer run center or an outpatient clinic depending on the level of care needed.

The approved TRIESTE Innovation project proposed to pilot the following five system changes:

1. A Recovery-Informed Reimbursement System
2. Recovery-Informed Documentation and Process-Monitoring
3. Recovery-Informed Performance Measurement
4. Shifting to the Provision of “Well-Being-Focused” Services
5. Technology that supports payment, documentation, and accountability reforms

Over the intended duration of the Innovation pilot study, Los Angeles County planned to observe and evaluate three broad questions to be assessed following the implementation of the five proposed system changes:

1. Are the lives of the people served by the Innovation pilot significantly improved over time across the variety of measures and indicators?
2. Are the outcomes within the pilot population significantly better or worse than the outcomes in the comparison population?
3. Are the costs of providing services to the pilot population greater or less than the cost of services provided to the comparison population?

Los Angeles County planned to engage a university-based evaluator to independently assess and report on the outcomes of the project. The assessment includes comparing the results and outcomes achieved with the target population in the Hollywood region with a demographically and fiscally similar comparison region and population within Los Angeles County.

It is our understanding that this project has not yet been approved by the county’s Board of Supervisors. According to their letter dated April 13,2021, the county indicates that due to COVID 19, they have had to shift their priorities based upon direction from their Board of Supervisors, the needs of their clients and those of the new clients that have emerged because of the pandemic.

Proposed Innovation Project Change
On April 13, 2021, Los Angeles County sent a letter to Executive Director Toby Ewing notifying the Commission of a proposed change to the TRIESTE Innovation project (aka Hollywood 2.0).

Under the Innovation regulations a change to an Innovation project that changes the basic practice or approach that the County is piloting and evaluating must receive prior approval from the Commission. (Title 9, California Code of Regulations section 3925)

Los Angeles County is requesting to **leverage Medi-Cal drawdown as a funding source** for the TRIESTE project, **instead of solely funding the project with Innovation dollars**. According to the April 13, 2021 letter, Los Angeles County is requesting to change the approved TRIESTE project by eliminating the following three of the five system changes in original project:

1. Recovery- informed reimbursement system
2. Recovery-informed documentation and
3. Technology that supports payment, documentation, and accountability reforms

Rationale for Change

Los Angeles County states in its letter that after the Commission approved the TRIESTE project, proposed Medi-Cal reform through CalAIM and others identified changes to reduce the current constraints of the Medi-Cal reimbursement system. According to Los Angeles these changes will not remove all the issues but will move the state in a direction to support many of the recovery-informed core elements incorporated in the approved TRIESTE pilot. These planned changes include removing diagnosis-first requirements to establish medical necessity and allowing reimbursement of social determinants of health informed services through Enhanced Care Management and In Lieu of Services reimbursement.

In addition, the County believes that through their work with Third Sector and their desire to transform their Full Service Partnership (FSP) programs, has further positioned them with the tools to successfully implement and test the programs and services outlined in the originally approved TRIESTE pilot.

While the original proposal identified Medi-Cal drawdown requirements as a barrier preventing true recovery-informed services, Los Angeles County suggests that the proposed Medi-Cal reform (CalAIM) and the learnings from their FSP work, allow them to offer recovery informed, well-being focused services without having to create and implement technology for new reimbursement and documentation practices.

The Commission may wish to ask the following questions:

- What is the estimated timeline for proposed reforms to be implemented?
- How will Los Angeles launch the TRIESTE (Hollywood 2.0) program and ensure fidelity to the recovery model while waiting for Medi-Cal reform to eliminate barriers in the reimbursement system?
- Will service providers still receive training on how to use recovery-focused, whole person approaches to care while complying with documentation requirements?
- Will Los Angeles County reduce the overall Innovation budget considering that the county is eliminating the need to develop a new reimbursement system?
- The Commission may wish to ask Los Angeles County to submit a revised timeline reflecting the removal of technology development and changes resulting from the COVID-19 pandemic.

Presenter for Los Angeles County's Innovation Project:

- Jonathan Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County

Enclosures (3): (1) Biography for Los Angeles County's Innovation Presenter; (2) 04.13.2021 TRIESTE Project Change Request Letter; (3) Original TRIESTE Proposal

Handout: NONE

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Biography for Los Angeles County Presenter

Jonathan Sherin, M.D., Ph.D., **Director of Mental Health, Los Angeles County**

Dr. Jonathan Sherin is a longtime wellbeing advocate who has worked tirelessly throughout his career on behalf of vulnerable populations. In his current role as Director of the Los Angeles County Department of Mental Health (LAC-DMH), he oversees the largest public mental health system in the United States with an annual budget approaching $3 billion.

Prior to joining LAC-DMH, Dr. Sherin served for over a decade at the Department of Veterans Affairs (VA) where he held a variety of posts, most recently as chief of mental health for the Miami VA Healthcare System. He has also held a variety of academic posts, formerly as vice-chairman for the Department of Psychiatry and Behavioral Sciences at University of Miami, and currently as volunteer clinical professor at both UCLA and USC.

In addition to his leadership in the health and human services sector, Dr. Sherin has made significant contributions to the field of neuroscience, which include seminal sleep research studies, published in Science magazine, and a conceptual model of the psychotic process for which he received the prestigious Kempf Award from the American Psychiatric Association.

Dr. Sherin completed his undergraduate work at Brown University, his graduate studies at the University of Chicago and Harvard Medical School, and his residency in psychiatry at UCLA.

DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

April 13, 2021

Toby Ewing, Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

Per our dialog over the course of this pandemic, the Los Angeles County Department of Mental Health (LACDMH) is interested in, and now formally requesting, that the Oversight and Accountability Commission permit minor adjustments to the Innovation (INN) Project ("Trieste, CA"). In short, LACDMH is planning to deliver the same program and services through the same resource array to create the same mental health ecosystem targeting the same population in the same geography but proposes to do so using a model that leverages Medi-Cal drawdown as a way to mitigate COVID-related fiscal uncertainties and also capitalize on imminent (and welcome) California Advancing and Innovating Medi-Cal (CalAIM) reforms.

Since approval of this project in May of 2019, our ***YourDMH*** stakeholder engagement (aka community planning) process has continued without interruption throughout the pandemic, during which we have maintained contact with constituents across LA County and developed the Mental Health Services Act (MHSA) Three-Year Plan. The Trieste INN Pilot (renamed "Hollywood 2.0" for various reasons including stakeholder input/request) has been discussed in this context and beyond on numerous occasions in general and more specifically when new updates were available. Multiple meetings with the primary Board office (Supervisorial District 3, Supervisor Kuehl) and the County's Chief Executive Office were held to discuss the project in principle as well as to develop the strategies and the infrastructure needed to implement the pilot successfully. In particular, the Department made clear its need to have adequate operational support for the pilot through additional, dedicated staff (a clinical leader, administrative manager, and administrative assistant) as well as a fiscal intermediary. In addition, numerous efforts to identify potential sites and facilities have been pursued by both the department as well as advocates in the Hollywood community. Further, advocates in the Hollywood community are working to identify landlords (with potential housing capacity) and business owners (with potential job opportunities) who are willing and able to support the pilot.

Needless to say, LACDMH, like the rest of the world, has had to shift to a new COVID reality over the past year in terms of how we even operate day to day. In addition, we have had to pivot our priorities based upon changing direction from the Board and the evolving needs of our client base, as well as the demand from many new clients across our collective who have deteriorated as a pandemic consequence. Chief among the many complicating factors we have faced as a result of COVID has been great uncertainty regarding losses in revenue from MHSA, Realignment and more. On that note, and of immediate relevance to this pilot, there have been efforts afoot in Sacramento led by the "Coalition" that aimed to permit counties to use unencumbered as well as encumbered but unspent INN funds as a way to backfill potential losses. In addition, we have been challenged with a variety of cost-saving (curtailment) exercises compelled at the local (county) level which have made moving forward with the project and its originally proposed funding plan untenable. In particular, we are not comfortable leaving Medi-Cal matching dollars on the table to have more flexibility in the use of INN funds for the Hollywood 2.0 project at the same time that the County is preparing for potential reductions in force and contract decreases. Of additional relevance on the reform side, with CalAIM the state is moving in a direction that incorporates many of the core elements we have proposed to improve care [(through Medical Necessity, Enhanced Care Management (ECM) and In Lieu of Services (ILOS) reimbursement (see next paragraph)]. With this whole perspective in mind, which we have been sharing with our wide spectrum of stakeholders from the community level to the Board level as the situation has evolved in real time over the course of the past year, we are proposing to use a funding model that optimizes federal match while still delivering the same array of resources to serve the same population with the same funding and the same goals, including our goal to continue guiding CalAIM and the upcoming 1115 Waiver.

While the constraints of Medi-Cal billing will not disappear with CalAIM, we are encouraged by the state's plan to remove the need for diagnosis first (as well as restricting management of co-occurring disorders) in establishing medical necessity for reimbursement, to reimburse for services that focus on social determinants through ILOS and its insistence that our most in-need clients get relentless care coordination through ECM. We believe that these imminent advances, along with the Full Service Partnership-reboot work we have been driving for over three years with support from the Ballmer Group and Third Sector Capital as well as our investment in an array of progressive, hospitality oriented built and non-built environments will deliver a successful (and more sustainable) pilot.

In terms of changes from the original proposal, recovery-informed reimbursement and documentation as well as the Information Technology infrastructure to support them will be unnecessary because we will be using Medi-Cal match and complying with Medi-Cal

requirements using existing and emerging administrative tools. That said, we remain entirely committed to the primary outcomes of the original proposal with a laser focus on our clients having "people, place and purpose" in lieu of being isolated, living in the asylums (streets and/or jails) and languishing without a role in community/society. In addition, we remain committed to ensuring that the arc of "wellbeing services," including not only care for mental and physical health as well as addictions but also psychosocial care and ongoing 24/7/365 access to peer (kinship) support are readily accessible. Lastly, we remain committed to the new brand of customer service that inspired this pilot, consistent with the radical hospitality approach found in the Trieste mental health system.

Please let me know next steps. I am happy to discuss with you, your staff, and the commission at any time and also know that my team, the Supervisors, other elected officials and the County collective are eager to move on this pilot which has been in an operational holding pattern since the pandemic began.

Sincerely,

Jonathan E. Sherin, M.D., Ph.D.
Director

JES:tld

The TRIESTE* Project:

*__T__rue __R__ecovery __I__nnovation __E__mbraces __S__ystems __T__hat __E__mpower

An Innovation Proposal to

The Mental Health Services

Oversight and Accountability Commission (MHSOAC)

Submitted by

The Los Angeles County

Department of Mental Health (LACDMH)

April 18, 2019

(Updated April 30, 2019)

PREFACE

In November 2017, a group of 13 Los Angeles County officials and leaders visited Trieste, Italy to observe and study its World Health Organization (WHO)-recognized system of mental healthcare. The delegation (which refers to itself as the "Tribe") was comprised of various stakeholders in our mental health system, most of whom find themselves at the nexus of mental health, homelessness and law enforcement policy and practice. In their professional roles, most of them are exposed – often on a daily basis – to heartbreaking stories of suffering experienced by people with severe and persistent mental illnesses who are also homeless, incarcerated, or simply living lives of quiet desperation in board and care facilities.

It is against this backdrop – and with the hope of finding alternatives that would better serve the most vulnerable and marginalized among us - that the Tribe travelled to Trieste to attend an international conference, "The Right and Opportunity to Have a Whole Life." The conference was sponsored by the Trieste *Dipartimento di Salute Mentale*, whose leadership also planned site visits apart from the conference to introduce the L.A. delegation to the Trieste culture and practice.

What the members of the Tribe discovered both surprised and delighted them. There is little if any homelessness in Trieste and involuntary psychiatric hospitalizations have been virtually eliminated. They had the opportunity to meet and learn from their counterparts in the Italian provider community: clinicians, social workers, law enforcement, judiciary and peers. The Tribe was particularly impressed by the system's ability to address the needs of the whole person – not just their illness – as well as the availability of and accessibility to off-hours and crisis services and the reduction of the need for inpatient psychiatric services.

Since their return, the Tribe has met regularly to consider ways to bring the principles and practices of Trieste to Los Angeles County. This proposal is the result of their ongoing discussions and reflects their hopes to improve mental health care for the most vulnerable citizens of Los Angeles County.

EXECUTIVE SUMMARY

The concept of recovery has become the dominant paradigm for the provision of mental health services. Nearly everybody with mental health challenges, even those with the most severe impairments, is considered capable of "a life in the community not defined by their mental illness." The Mental Health Services Act – the defining document for the provision of mental health services in California – requires an approach that goes beyond treating the symptoms of the illness and instead focuses on ensuring that people with mental illnesses have appropriate housing, social connection and belonging and purpose in their lives.

And yet, for all the acceptance and promotion of the recovery model, the actual on-the-ground results appear to be mixed at best. The increasing numbers of homeless people with a mental illness and the system's relative inability to help people to achieve true community inclusion both suggest that there is something missing in the way that the recovery vision is being implemented.

It is our premise that the single greatest reason for our system's failure to deliver on the promise of the recovery model is to be found in the way that we finance mental health care in the United States. At its core, the U.S. mental healthcare system is driven by two closely related factors:

(1) compliance with the Medicaid-based fee-for-service payment system and its copious associated regulatory processes that are intended to ensure accountability, and
(2) an over-emphasis on the treatment and mitigation of the symptoms of the illness rather than on the well-being of people served and their re-integration into the community at large.

In essence, our current payment and funding systems – presumably out of their concern for "fiscal accountability" – constrain and restrict our best intentions to actually meet the needs of the people we serve. If the recovery model is to ever actually fulfill its promise, we must create new and innovative payment, accountability and documentation systems that free us from the bureaucratic constraints that prevent us from providing the services that people actually want and need.

This MHSA Innovation Project proposes to implement five related innovations to create a pilot project that will demonstrate how both individual and system outcomes and consumer satisfaction in our mental health system can be dramatically improved without increasing the cost of services.

These five innovations are:

A. A Recovery-Informed Reimbursement System
B. Recovery-Informed Documentation and Process-Monitoring
C. Recovery-Informed Performance Measurement
D. Shifting to the Provision of "Well-Being-Focused" Services
E. Technology that supports payment, documentation and accountability reforms

While for narrative reasons we will address each of these innovations in turn, it is important to note that we believe that these innovations are closely-related and all are necessary components of a true recovery-informed systems approach.

Background

In late 2017, a group of thirteen Los Angeles County officials and leaders took on the task of examining the reasons for the suboptimal performance of the mental health system in the Los Angeles County. In November of that year, the group (hereafter referred to as "the Tribe") visited Trieste, Italy, to attend an international conference, "The Right and Opportunity to Have a Whole Life" and study the local mental healthcare system which is recognized as an exemplary system by the World Health Organization and celebrated by experts in the field. Among the many key observations made during their visit: 1) there are essentially no homeless people with a mental illness in Trieste; 2) the jails are not overcrowded with inmates with a mental illness, and; 3) involuntary psychiatric care has been virtually eliminated.

Though there are surely a multitude of factors accounting for these observations that contrast so dramatically with L.A. County, it is our contention that the most significant reasons for the differences in outcomes are 1) the ways the two systems are financed and 2) the enormous difference in their bureaucratic, regulatory and reporting requirements. The staff in Trieste are blissfully unaware of and unconcerned with how the services they provide are paid for. Staff are able to do "whatever it takes" because they are not concerned that an audit will determine that the service they provided did not meet the criteria for "medical necessity." And staff do not spend anywhere near the 25% of their time documenting the services they provide that is typical in Los Angeles.

INNOVATION A: A Recovery-Informed Reimbursement System

Unlike the capitated system of Trieste, our public mental health reimbursement system is characterized by a fee-for-service reimbursement model that requires staff to bill by the minute (or hour or day, depending on the service). This reimbursement model diverts staff attention away from the care they are providing and the needs of the members they are serving to whether they are meeting their "billing goals."

Furthermore, the fee-for-service reimbursement model creates a perverse incentive to provide more services (greater volume) than may be actually necessary for the member because the provider gets paid more as the amount of service increases. Because of the individual staff person's need to provide billable hours, it becomes tempting to provide additional services even though they may not be needed or desired by the member.

We believe that a reimbursement system that provides funding based on the outcomes of services (paying for value) rather than for the quantity of services provided (paying for volume) is best suited to provide the financial and accountability underpinnings for a true recovery-oriented system of mental health services. Therefore, we intend to implement a multi-tiered case rate system in which funding is based on the level of need of the persons served and is completely uncoupled from the amount of service provided. This approach will encourage and empower our caregivers to attend more flexibly to the successful personal recovery and community integration goals of those with serious mental health problems instead of forced compliance with relentless regulatory processes.

INNOVATION B: Recovery-Informed Documentation and Process Monitoring

The pilot project will implement a process-monitoring and documentation system that encourages staff to relate to their members as whole people rather than just to their illness. To promote the provision of well-being-focused rather than illness-focused services, we propose to completely eliminate the current Medicaid service classification system and replace it with a monitoring system that addresses all aspects of the member's quality of life as well as describing what the staff person actually did in his/her interaction with the member. All services will be designed to help members achieve the following goals:

(1) A safe and healthy home in the community (HOME & HEALTH),
(2) Acquiring and maintaining familial, social and intimate relationships (LOVE AND BELONGING), and
(3) Acquiring and maintaining meaningful roles in the larger community (PURPOSE).

Implementation of this system will ensure that staff are addressing the needs of the whole person – not just the illness – as well as having the effect of significantly reducing documentation time and increasing time for the actual provision of care.

INNOVATION C: A Recovery-Informed Performance Measurement System

Our current system is characterized by a focus on monitoring (and paying for) services based on the quantity of the services provided regardless of their effectiveness. The

pilot will shift away from this type of process monitoring by fully implement the existing Key Event Tracking System (KETS) currently used by the State of California to track outcomes for Full Service Partnership (FSP) programs. These indicators will enable us to judge the pilot's effectiveness in increasing independent living and employment and reducing rates of incarceration and hospitalization in the population served.

In addition, we propose to implement a two-component system that measures our pilot's effectiveness in helping our members to develop the skills and the supports that they need to live in the larger community. The components of this system are the Milestones of Recovery Scale (MORS) and the Determinants of Care. The MORS defines recovery beyond symptom reduction, client compliance and service utilization. It sees meaningful roles and relationships as the driving forces behind achieving recovery and leading to a fuller life. The Determinants of Care help staff to understand which specific life domains the member is able to self-coordinate and the domains for which s/he needs either natural or professional support. Over time, it is expected that the member will learn to self-coordinate more aspects of his/her life.

The pilot will be able to evaluate its effectiveness in helping our members to become more self-coordinating, which in turn is expected to help the member to live more successfully in the larger community.

INNOVATION D: The Proposed Service Array: Shifting the Balance from "Illness-focused" Services to "Well-being-focused" Services

The most foundational service offered in the pilot will be to act as the member's health home in which both the mental and physical healthcare needs of the member can be addressed. Members will be assigned to a health home that reflects and is congruent with their level of need and their ability to self-coordinate their care. Wellness and Peer-Run Centers, Outpatient Clinics and FSPs could all serve as the health home for the member, with each of these levels of care providing the appropriate (i.e., needed) amount of assistance for the member to achieve the maximum level of independence in the community.

It is our belief that implementing innovations A, B, and C will create the financial and regulatory environment in which true, recovery-oriented, well-being focused services are most likely to thrive and achieve their intended effect. But to increase the likelihood of the success of this endeavor even further, the pilot intends to employ a trauma-informed, culturally competent approach that reverses the usual emphasis between clinical and psychosocial services by making the psychosocial services "primary" and the clinical services "ancillary." For example, a wide variety of supported employment and supported education services will be available as well as an emphasis on leisure

and recreational opportunities. But in all services offered, staff will be aware of the significant roles that trauma and racial, ethnic and gender disparities play in the lives of the people we serve.

While we of course recognize that many of the members we serve require very high levels of traditional clinical services and supports (e.g., therapy, medication support), we also believe that we must constantly remind ourselves of and focus on the whole life the member is trying to lead in spite of having a severe and persistent mental illness. It will be the extensiveness and robustness of these psychosocial, non-illness centered services that will to a large degree determine our success in this endeavor.

The pilot will also implement new levels of crisis and emergent services including Peer Respite, Crisis Residential, and Urgent Care that currently do not exist in the proposed pilot region.

INNOVATION E: Technology that supports documentation, accountability and payment reforms

The Reimbursement/Documentation/Accountability system proposed in Innovations A – C will require a significant investment in technology to realize its potential to reduce the documentation burden on staff and improve the effectiveness of care. We envision a HIPAA-compliant electronic health record that is accessible through a smart phone application. Staff will record not only their interactions with individual members but ALL the activities in their work.

Data will be entered into the EHR database either wirelessly or when staff return to the facility and dock their phone with the system.

It is expected that this voice-enabled system will reduce keyboard data entry by as much as 90% and thereby reduce the data entry time for staff by several orders of magnitude. It also has the benefit of being much more accurate and reliable in that it requires staff to enter their documentation on an ongoing, real-time basis.

SUMMARY

For at least 30 years, the recovery model has held out the promise of a system that will achieve true community inclusion for people who are marginalized by their experience with severe and persistent mental illnesses. That promise remains unfulfilled. It is our belief that the primary reason it remains unfulfilled is that our bureaucratic and regulatory systems have not kept pace with or supported our improved approaches to service. This innovation proposal offers a roadmap as to how to create a “recovery-oriented bureaucracy” – which we do not believe to be an oxymoron! To the contrary, we believe that the innovations described here will improve our effectiveness (better

outcomes) and will increase both staff morale and member satisfaction with the experience of care.

We believe that ultimately this project has the potential to transform the mental health system in the United States. We respectfully request that the Oversight and Accountability Commission fund this proposal.

BUDGET

This proposal to the Mental Health Services Oversight and Accountability Commission (MHSOAC) aims to obtain approval for the resources we need to administer and study a pilot system over a five-year period. In the first year of the project (July 1, 2019 – June 30, 2020), $11,850,000 is budgeted to reflect upfront, one-time infrastructure investment for purchasing and renting facilities as well as designing, implementing and supporting electronic health record technology. The first year of the project will be used to engage community stakeholders, secure all necessary regulatory waivers, establish evaluation contracts and protocols, and site new services.

New services will actually begin on July 1, 2020 and the pilot will run through June 30, 2024. The baseline annual budget will be $26,225,000 per year which reflects the current cost of all adults served in the geographic region over the 2017-18 fiscal year (approximately $18,000,000) plus the funds needed to add a number of new services plus the cost of the evaluation of the pilot.

Thus, total funding requested for the entire five-year innovation project totals $116,750,000 ($11,850,000 + ($26,225,000 * 4 years)).

Within three years of launching the pilot, we anticipate that we will begin to see not only improved outcomes and customer satisfaction among the members we serve, but will also see improved morale among service providers. It is our hope and expectation that within five years we will achieve sufficient proof of concept to feel confident expanding the model across our county's mental health system. Ultimately, we are hopeful that the model will be so successful that we will be able to convince not only the state of California but also the federal government that the Medicaid financing and accountability system should be changed to reflect what we demonstrate though this project in Los Angeles County.

Proposed Timeline for Implementation – First 20 Months

November, 2018

- Initial draft of concept paper completed

December, 2018

- Determination of the geographic boundaries of the pilot

March, 2019

- "Final" draft of concept paper completed
- Determination of the precise population to be served and initiation of economic analysis of current county expenditures for the population
- Expanded stakeholder process to vet concept paper begins
- Submission of concept paper to MHSOAC

April, 2019

- Initial presentation to members of the MHSOAC

May, 2019

- Submission of full proposal for five-year innovation grant to the MHSOAC with expectation that grant will be awarded to begin effective July 1, 2019 through June 30, 2024.
- Initial discussions/negotiations with potential independent evaluators to determine scope and cost of the evaluation
- Initial discussions/negotiations with potential EHR vendors to determine scope and cost of the new EHR.
- MHSOAC officially awards Innovation Grant (MH Month!)

July 1, 2019 – June 30, 2020

- Securing all necessary regulatory waivers
- Expanded stakeholder process to determine scope and implementation of services
- Selection of independent evaluator and implementation of evaluation protocols
- Selection of EHR vendor and implementation of system
- Initial training of staff on all data collection and accountability systems

July 1, 2020

- Doors open and services begin under the pilot project.

The TRIESTE* Project:

*True Recovery Innovation Embraces Systems That Empower

> *Community care cannot really be effective if it aims simply at efficiency in the management of target populations, defined by their illness and/or related deviant behaviors (Basaglia, 1987). It must strive to preserve the idea of the person as a whole, while combating social exclusion and new forms of institutionalization. (Mezzina, 2014)*

The Trieste Community Mental Health System (adapted primarily from Mezzina, 2014)

By many accounts, since the early 1970s the community mental health system in Trieste, Italy has served as an inspiration and a model to European states and cities seeking to improve their systems of care for people with mental illnesses. Under the direction of Dr. Franco Basaglia, in 1973 Trieste became a World Health Organization (WHO) pilot center for deinstitutionalization and community mental health care. In 1987, the Trieste Department of Mental Health was declared a WHO Collaborating Center.

In 1980, the San Giovanni Hospital, then with a daily census of up to 1200 patients, became the first long-term psychiatric hospital in Europe to close and the staff and resources were reassigned to a much more community-based system of care. While phasing it out, a complete alternative network of community services was set up and today consists of the following services and programs:

- four Community Mental Health Centers (CMHCs), each responsible for a catchment area of 50,000 to 65,000 inhabitants, all open 24 hours a day, with four to eight beds each.
- one General Hospital Psychiatric Unit (GHPU) with six beds, mainly used for emergencies at night, with very short stays of usually less than 24 hours.
- the Habilitation and Residential Service, which has its own staff and cooperates with nongovernmental organizations (NGOs) in managing approximately 45 beds in group homes and supported housing facilities at different levels of supervision up to 24 hours a day, as well as two day-care centers.

Another extremely important feature of the Trieste model is the use of accredited social cooperatives to provide training and meaningful roles for its service recipients. Work activities include agriculture, building, cleaning, tailoring, hotel operation, restaurant, and home catering businesses. All workers, except trainees, are voting members of the cooperative businesses.

The leaders of the mental health system in Trieste, however, would argue that it is the philosophy of care that is much more important than any specific services or programs that their system offers to their service recipients. Those principles and values include the following (adapted from Trimbos, 2012):

1. A holistic approach: in mental healthcare, the individual, and not the disorder, is emphasized. There are no patients or clients, but users, *'utenti'*. Social exclusion is seen as a result of the medical model with its particular language, hierarchical relations and structure. The 'relational world view' is expressed by the following:
    a. An individual's needs are assessed on the basis of his personal story/history, which also addresses his social relations, from family to neighborhood.
    b. In order to meet the needs of a user, personal relations between care workers and users are considered central.
    c. Services are evaluated in terms of personal routes to recovery and empowerment. To back up this idea, the community service center is open 24-7.
2. An ecological approach: the emphasis is on the social context, the network and the social groups to which an individual belongs. Care is offered by the community, is outreaching, proactive and accessible, and aims at social inclusion. Care workers enter into relationships with the individual and his family, with housing services etc. The community center offers prevention, as well as basic and specialist treatment for all users in the region for which it is responsible; because of its 'territorial responsibility' for users, the community center cannot transfer patients with complex problems to other centers.
3. A legal approach: there is an emphasis on the civil rights of individuals with psychiatric problems, both in a legal and a social perspective. To create a community which guarantees inclusion and the possibility that everyone can exercise their social rights, a support network is essential. Deinstitutionalization means having individual control over one's own route to recovery.

Payment Reform and the importance of how we pay for services

Having observed and studied the mental health system in Trieste, it is our conclusion that the most significant differences between the mental health system in Trieste and ours in Los Angeles are: 1) the ways the two systems are financed and 2) the enormous difference in their bureaucratic, regulatory and reporting requirements. The staff in Trieste are blissfully unaware of and unconcerned with how the services they provided were paid for. Contrast this with our Medicaid system in which staff must be constantly aware of the financial ramifications of the services they are providing and whether they

meet the criteria of “medical necessity.” These requirements make it extremely difficult for staff to provide the kind of whole person care that typifies the system in Trieste.

We have concluded that the most critical innovation needed to improve our L.A. County mental health system is the adoption of a financing system that relieves the direct service staff person of any focus on the financing of the service and thereby frees up and encourages the staff to address the “whole person.” This will require movement away from the current fee-for-service model and adoption of a tiered case rating system, the details of which will be explained in Innovations A below.

Related to and nearly as important as the financing system is the need to create a recovery-informed monitoring system that focuses on the whole person (Innovation B) and a performance measurement system that moves us toward a focus on outcomes (Innovation C). This does not mean completely abandoning the monitoring process, but it requires us to streamline our monitoring processes and redesign how we use that information to improve services and inform staff about their performance.

INNOVATION A: A Recovery-Informed Reimbursement System

As mentioned above, one of the most striking differences between the mental health system in Trieste and the L.A. County public mental health system is the manner in which services are reimbursed. Trieste is characterized by a capitated system in which every resident of the city is covered by a single mental health system and the mental health center receives a set amount per resident per year (Currently $88 US). For these funds, the system is expected to provide for all the needed mental health services for the entire population of a defined region, including crisis and inpatient services.

Unlike the capitated system of Trieste, our public mental health reimbursement system is characterized by a fee-for-service reimbursement model that requires staff to bill by the minute (or hour or day, depending on the service). This reimbursement model diverts staff attention away from the care they are providing and the needs of the members they are serving and shifts it to whether they are meeting their “billing goals.” Furthermore, the fee-for-service reimbursement model creates a perverse incentive to provide more services (greater volume) than may be actually necessary for the member because the provider gets paid more as the amount of service increases. Because of the individual staff person’s need to provide billable hours, it becomes tempting to provide additional services even though they may not be needed or desired by the member.

For all these reasons, it is clear that our current bill-by-the-minute fee-for-service reimbursement model needs to be scrapped. But with what should it be replaced? Because of the public-private distinction mentioned earlier, having a single capitation rate that applies to the entire population within a given geographic region is impossible

because the majority of people living in any given region is covered by the private – not the public – system. In addition, because it is the people with the most severe and persistent mental health needs who have been "carved out" of the general population and placed in the public mental health system, the per capita costs of serving them will be much higher than the costs of serving the general population.

We believe that a reimbursement system that provides funding based on the outcomes of services (paying for value) rather than for the quantity of services provided (paying for volume) is best suited to provide the financial and accountability underpinnings for a true Trieste-like recovery-oriented system of mental health services. Therefore we suggest the implementation of a multi-tiered case rate system in which funding is based on the level of need of the persons served and is completely uncoupled from the amount of service provided.

As it happens, a real-world experiment in this model was undertaken right here in Los Angeles County and it is to that example that we now turn.

Back to the Future: The Village Integrated Service Agency Case Study

On July 1, 1990, Mental Health America of Los Angeles (MHALA – then known as the Mental Health Association in Los Angeles County) opened its Village Integrated Service Agency in Long Beach, California. The Village ISA, as it was then known, was modeled on a combination of the Assertive Community Treatment model and the Fountain House Clubhouse model. Many articles and papers have been written about the Village, its philosophy and practices, and its success in treating its members.

What is less well-known about the Village ISA is that it was implemented as a true random-assignment clinical trial to test whether the services offered were actually more effective than the "usual and customary" services being provided in the same local community. People who were recruited for the study were told that they had a 50% chance of being assigned to "a new model of mental health care" or to the existing mental health clinic. 120 individuals were randomly assigned to the Village and 120 individuals were assigned to the comparison group. The recruitment and randomization were done under the supervision of an independent research firm that was also engaged to conduct the follow up evaluation on effectiveness and efficiency of the Village vs. the comparison group.

After a three-year evaluation, the independent evaluator issued a report on the project, the main results of which appear in Table 1. In summary, the results of the Village ISA were significantly better than those of the comparison group in a number of domains, including reduced hospitalization and institutional care, more satisfaction with services and less burden on family members. On the expense side, the report estimated that the Village expended $300,000 less on hospitalization than was expended on the members

of the comparison group. The Village psychiatrists had admission and discharge privileges at a local hospital and paid very close attention to when a member needed to be hospitalized and when they could be discharged. We believe that this was one of the primary reasons that Village members' hospital stays were significantly shorter than those of members in the comparison group.

INDEPENDENT EVALUATOR'S FINDINGS:

MAJOR HIGHLIGHTS

- Village members had significantly fewer hospital days than the comparison members. Village members also had significantly lower costs for inpatient care.
- At the Village, 72.6% of members tried paid employment over a three-year period, compared to 14.6% of the comparison group.
- The percentage of Village members living in group and institutional settings declined from 15.8% at baseline to 10.8% after three years. Among the comparison members, the percentage remained fairly constant from 23.7% at baseline to 23.2% after 3 years.
- Village members reported more solitary leisure activities and more activities with others during the week before the interview than did comparison members. Village members reported significantly more support at each of the three annual interviews.
- Families of Village members reported significantly less burden and less stress from burden than did family members of the comparison group. Families of Village members also were much more positive about the member's hopes for the future than families of the comparison group.
- Members at the Village were significantly more satisfied with mental health services than members in the comparison group.

In Chandler, D., Meisel, J., Hu, T., McGowen, M., & Madison, K. Client Outcomes in a Three-Year Controlled Study of an Integrated Service Agency Model. *Psychiatric Services*, December, 1996, **47**, No. 12, pp. 1337-1343.

Table 1

What was also unusual about the Village ISA was the mechanism of its funding. MHA was paid $15,000 per member per year (a single-tier case rate) and for those funds was expected to provide all mental health services for its 120 members including inpatient hospitalization. In other words, MHA was at full-risk for the cost of the services to the members and was therefore incentivized to keep high-cost, inpatient services as low as possible. Because California provided general funds for the project and no Medicaid was involved, there was no minute-by-minute billing requirement and the only

documentation required of the staff was a monthly summary of the member's progress. Responsibility for tracking the outcomes of the Village and comparison group members was given to the independent evaluator, who conducted interviews regularly both with the members as well as their families.

SERVICE EXPENDITURE PATTERNS: VILLAGE vs. COMPARISON GROUP

	Village	Comparison
Type of Service	**Percent of Total**	**Percent of Total**
Case Management	40.6	10.1
Day Treatment	0.2	1.0
Medications	11.2	10.2
Residential	0.3	2.1
Socialization	11.6	1.2
Outpatient Therapy	4.7	23.2
Vocational	25.1	1.3
Acute Hospital	5.1	27.9
Long Term Care	1.3	23.1

The three largest areas of expenditure for the Village members were in case management, employment services and socialization services. The three greatest areas of expenditure for the control group were acute hospitalization, outpatient therapy, and long-term care.

In Lewin-VHI, Inc., with Meisel, J., & Chandler, D. The Integrated Service Agency Model: A Summary Report to the California Department of Mental Health, June, 1995.

Table 2

Another striking result is that Village members were nearly ***five times more likely to engage in employment activity*** than members of the comparison group. We will return to this finding when we address Innovation D.

While the specific recovery practices in which the Village staff engaged are undoubtedly part of the reason for these positive outcomes, it is also extremely informative to observe the differences between how funds were expended on Village members vs. how they were expended on members of the comparison group (See Table 2).

What is most striking in these results is that the Village ISA spent approximately four times the percentage of its budget on case management as did the staff providing

services to the comparison group. Similarly, the Village ISA spent approximately 10 times as much of its budget on socialization as did the staff serving members of the comparison group. And finally, as a percentage of its budget, Village ISA staff spent nearly 20 times as much on vocational services as the staff serving the members of the comparison group.

We suggest that a very large part of the reason for the marked difference in service expenditure patterns between the Village and the comparison group is that the staff of the Village were completely unencumbered by the fee-for-service reimbursement model that had to be followed by the staff serving members of the comparison group. Much like the staff in Trieste, the Village ISA staff were effectively insulated from those kinds of considerations which freed them to be able to offer whatever services the member needed and/or requested.

Implementing a Multi-Tier Case Rate System

The case study of the Village ISA demonstrates that the case rate model of reimbursement is much superior to our current fee-for-service model and is likely to create an environment in which a Trieste-like system can thrive. However, if we are to adopt such a reimbursement model, it is necessary that the system be multi-tiered rather than the single-tier system that characterized the Village. When the Village ISA opened its doors in 1990, the belief that people could truly recover from severe and persistent mental illness had not yet taken hold. As a result, no thought was given to the idea that, as people get better, they require less care and the costs of supporting them over time should decrease. To the contrary, it was rather disparagingly assumed that “once a high utilizer, always a high utilizer.”

Over the last several decades, a lot of evidence has accumulated that this assumption is untrue. Many people who were significantly impaired and whose costs of care were extremely high have been able to live productive lives in the community at large with correspondingly extremely low costs for their care. Our reimbursement system needs to take this reality into account. It is a multi-tier case rate system that both reflects this dynamism in the individual’s costs of care over time while simultaneously providing the optimal environment in which staff can provide flexible and creative whole person care.

We are proposing that a specific geographic region be “carved out” to serve as a demonstration for a Trieste-like system of care that employs a multi-tier case rate reimbursement system. The population to be served would be every inhabitant of the defined region who is currently eligible for Los Angeles County funded services (generally, the Medicaid specialty mental health population). The proposed system would be revenue and expense-neutral; that is, it would reflect the total current funding for the region currently used by the defined population. But it would establish four to

five case rates that reflect average expenditures for people at different levels of need/impairment and therefore require different levels of care.

Some of the foundational work for establishing a multi-tier case rate system has already been done in Los Angeles. In 2014, a number of agencies in the Association for Community Human Services Agencies (ACHSA) established the Full Service Partnership (FSP) Integration Pilot. This pilot was initiated under the assumption that our healthcare systems would ultimately move toward a pay-for-performance system and the intention was to be "ahead of the curve" when that change finally took place. These agencies agreed to employ the Milestones of Recovery Scale (MORS) and the Determinants of Care (see Innovation C on pages 25 - 29 for a detailed explanation of these measures) as a means of assigning their members to a specific level of care. They further agreed to then track the movement of their members through the various levels of care with the ultimate goal of determining our ability to improve the lives of people served while simultaneously lowering the costs of their care.

LEVEL OF CARE	RULE PARAMETERS
5 Residential / inpatient services for people who are gravely disabled or are currently a danger to self or others	If MORS score is a 1 then LEVEL OF CARE is a 5
4 High Intensity Community Based OP	If MORS score is a 2 or 3, then LEVEL OF CARE is a 4 and/or If sum of determinants equals 5 or more, then LEVEL OF CARE is a 4 and/or If sum of determinants equals a 3 or 4 and one of those determinants is required weekly care coordination, then LEVEL OF CARE is a 4
3 Moderate Intensity Community Based OP	If sum of determinants equals a 3 or 4 and required weekly care coordination IS NOT one of those determinants, then LEVEL OF CARE is a 3 and/or If sum of determinants is 2 or less and MORS score is 4 or 5, then LEVEL OF CARE is a 3 and/or If sum of determinants is 2 or less and MORS score is 6 or 7 and the client has been stable at the current MORS score for less than 6 months, then LEVEL OF CARE is a 3
2 Wellness Services	To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.
1 Recovery Maintenance	To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.

Table 3

Table 3 above is a hypothetical algorithm that demonstrates how various combinations of the individual's MORS score and the sum of his/her determinants could be used to assign him/her to a particular level of care.

This system of determining levels of care is based on the following assumptions:

- The single greatest indicator of the overall cost of services is the amount of time staff must spend with clients.
- The less "self-coordinating" a client is, the more time staff will need to spend with them. Therefore, the practical goal of services is to help clients to become more "self-coordinating" over time.
- "Self-coordination" must be operationally defined by specific, actionable behavioral domains that staff can assist clients to learn and accomplish on their own.
- Levels of care can be objectively determined and will reflect the level of clients' ability to self-coordinate.

This algorithm is provided for demonstration purposes only. The actual criteria for assigning members to a specific level of care would need to consider both clinical and economic factors and take the specific population in the intended demonstration area into account. But this example demonstrates how such a system could rationally allocate resources to members and provide reimbursement for services based on their level of need while allowing us to track our ability to move them to lower levels of care over time.

The system also has the benefit of getting "double duty" out of our performance indicators. In Innovation C we will describe how the MORS and the Determinants of Care will be used as outcome indicators. there are no additional measures needed to track level of care, again minimizing the documentation impact on staff.

INNOVATION B: Recovery-Informed Documentation and Process Monitoring

Clinical providers, both County directly-operated and contracted providers, expend enormous resources ensuring that their staff enter all their billing data into the system to ensure that they are reimbursed for the services they provide. It is estimated that up to 25% of the direct service staff person's time is spent on billing and documentation. And of course the more time that staff spend documenting services the less time they have to actually provide services to their members.

But in addition to the burden of simply entering the amount of time expended in serving the member, direct service staff are expected to demonstrate that the service they provided meets the burden of "medical necessity;" that is, they must narratively justify that the service provided was medically necessary to address the member's needs. Failing to do so will result in the possible withholding of payment for the service.

It would be difficult to overstate the soul-killing effect this system has on the morale of staff in our mental health system. It is our contention that this system of reimbursement/documentation makes the adoption of Trieste-like recovery-oriented service system extremely difficult if not completely impossible. First, the very term "medical necessity" tends to focus on the member's illness rather than on the member's larger quality of life needs and goals. In their concern over providing a service that may not be reimbursed, staff will tend to gravitate toward a more illness-based intervention because it is perceived as "safer" from a reimbursement standpoint.

It should be pointed out that nobody is suggesting that there should be no accountability standards for staff. But process monitoring is important not for the traditional reason of ensuring reimbursement, but to allow systems to learn what is working and what isn't. We should strive for documentation standards and evaluation systems that will support and incentivize good recovery-oriented practices on the part of our direct service staff. We believe that the characteristics of such a process monitoring system would include the following:

- Process indicators that are meaningful and understandable for all stakeholders in the system: members, direct service staff, supervisors and middle-level management, executive leadership, elected officials and funders, and the public at large.
- Process indicators that trace and are consistent with and specific enough to reflect the individual member's "recovery journey" and provide direction to staff as to whether interventions are working.
- Process indicators that reflect the needs and goals of the whole person.
- A system that requires no more than 5% of the individual staff person's time to be spent on documentation and evaluation.

<u>What part of the member's whole life (what domain) did you and the member work on? (Component 1)</u>

To accomplish this, <u>we propose to completely eliminate the current Medicaid classification system and replace it with a two-component process-monitoring system that addresses all aspects of the member's quality of life as well as describing what the staff person actually did in his/her interaction with the member</u>. At every contact with a member, the direct service staff will record which quality of life domain was the primary focus of the interaction (Component 1). The quality of life domains include the following:

1. Residential (HOME & HEALTH)
2. Employment (PURPOSE)
3. Education (PURPOSE)

4. Financial (HOME & HEALTH)
5. Independence (HOME & HEALTH, PURPOSE)
6. Physical Health (HOME & HEALTH)
7. Substance Use / Abuse (HOME & HEALTH)
8. Legal (HOME & HEALTH)
9. Family / Intimate / Social relationships (LOVE & BELONGING)
10. Mental Health (HOME & HEALTH)
11. Leisure / Recreation (PURPOSE, LOVE & BELONGING)
12. Spirituality/Identity (PURPOSE, LOVE & BELONGING)
13. Other

These twelve categories capture virtually all aspects of an individual's quality of life. (The ubiquitous "Other" is included as a placeholder for some domain that we may have neglected to consider). Note that each of these quality of life domains is tied to one or more of the three primary goals of the pilot. At every interaction between staff and member, staff would be expected to record the quality of life domain that was the focus of the service provided.

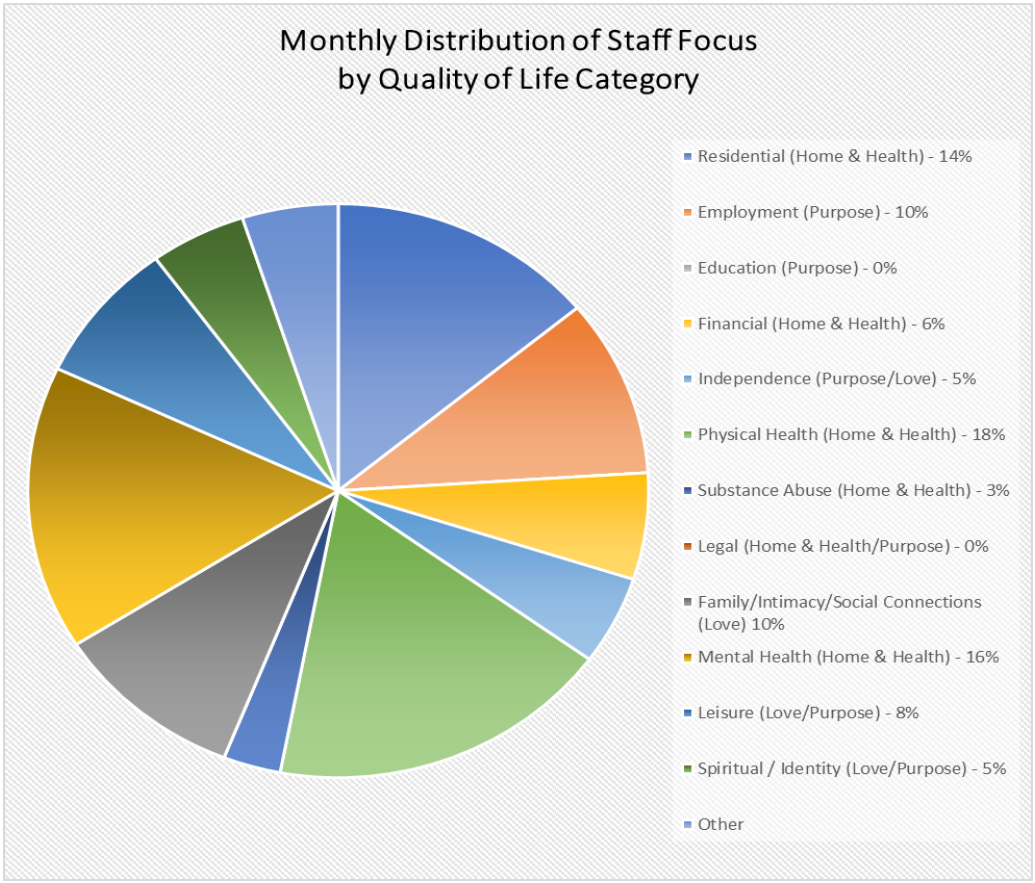


Figure 1

Figure 1 above provides an imaginary illustration of how a staff person might distribute his time over his overall caseload. Compared to other staff, he might spend significantly more time tending to the physical health needs of members because that is a specialized area of his scope of practice compared to other service staff.

Recording this simple piece of information has enormous ramifications for the improvement of services. It reminds the staff person at every interaction that they are working with a whole person who has goals and needs not just defined by their illness.

It also allows supervisors, programs and systems to monitor the amounts and percentages of time that direct service staff spend attending to various aspects of their members' lives.

But more importantly, imagine how these data for individual staff members could be "rolled up" and aggregated to demonstrate the extent to which not just individual staff, but how programs, agencies and larger systems are addressing the overall quality of life of the members they serve! This is information that is currently unavailable and, lacking that information, there is absolutely no way to know if our staff are making progress in our efforts to address the "whole person" and helping them to find "places to live, people to love and purpose every day." But having this information will enable us to transform into a "whole person-oriented" system.

<u>But what did you DO with the person? (Component 2)</u>

As was mentioned earlier, our current Medicaid-based documentation system does require staff to classify the services they provide. However, that classification system has relatively little utility because the categories are designed primarily to determine how much will be reimbursed for each service rather than providing information regarding what the staff person actually did with the member. To be fair, the system does expect the staff person to provide a narrative of what was actually provided during the service and how it addresses "medical necessity." But the fact that it is narrative and not standardized means that there is no way to aggregate the data or extract any general learning for the program, agency or system at large.

As an alternative, we intend to adopt a standardized list of services that are intended to reflect the "typical" experience of members at different points on their recovery journey. These recovery-based service categories include:

1. Welcoming / engagement
2. Crisis interventions / Responding to basic safety needs and community expulsion threats
3. Assessments and planning
4. Building and maintaining the safety net / "protective factors"
5. Motivating / Engaging in growth-oriented activities

6. Promoting mental wellness and treating mental illnesses and substance abuse disorders to reduce barriers
7. Promoting physical wellness and treating physical illnesses
8. Providing and building support
9. Rehabilitation / Skill building
10. Building personal growth and responsibility
11. Community integration
12. Community development
13. Promoting self-reliance, separation from services, and graduation

A description of each service category is provided in Appendix 1.

Example: Nurse

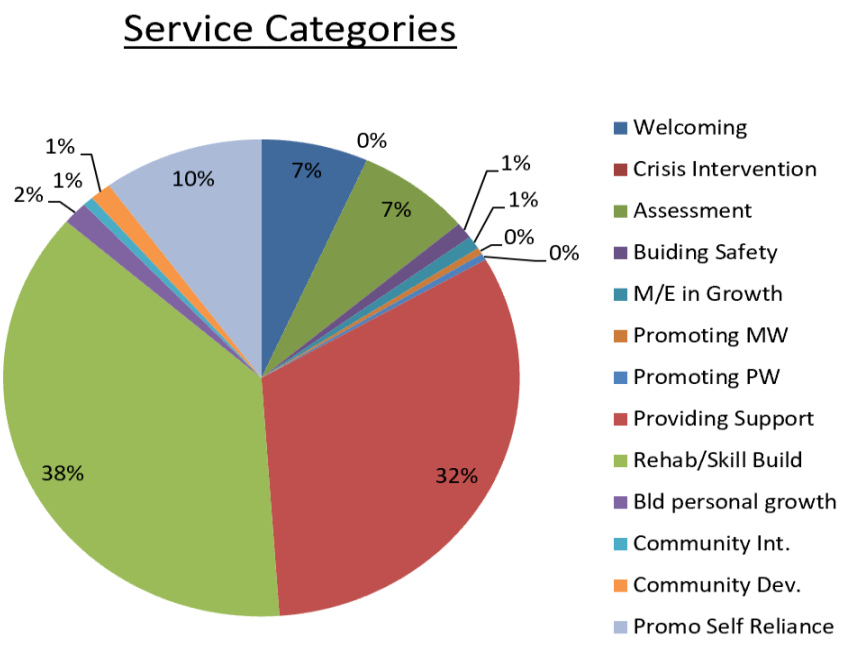


Figure 2

Figure 2 offers a hypothetical example of the distribution of services for one staff person.

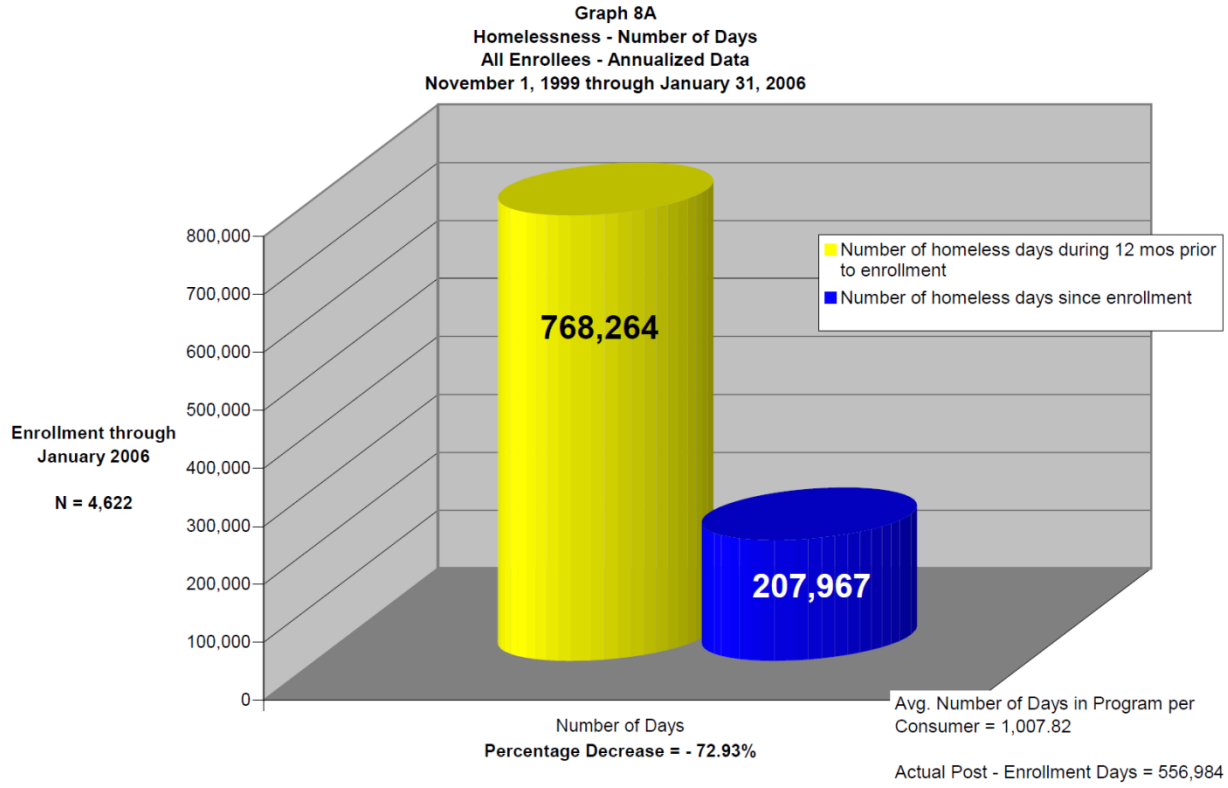
All staff would need to be trained on this system to ensure sufficient understanding of the service categories and reliability across staff. But along with the Quality of Life monitoring (Component 1), this classification system would ensure a whole person recovery-oriented focus and provide invaluable information at the individual as well as

the aggregate levels. It provides a tool to supervisors to help their staff to examine what might not be working in their interactions with any particular member and a framework for understanding the member's recovery journey.

INNOVATION C: A Recovery-Informed Performance Measurement System

As important as it is to incentivize and monitor service interactions that are whole person- and recovery-oriented, it is actually even more important that we have a means to determine if all those services are having the intended effect; that is, are we actually helping the people we serve to recover?

In 2005 the State of California implemented an outcome tracking system for all of its Full Service Partnership (FSP) programs serving the highest need members with severe and persistent mental illnesses. This system, called the Key Events Tracking System (KETS), monitors and records changes in certain domains in the member's life. For example, at entry into an FSP, the member's current residential status is recorded (e.g., homeless through living independently) as well as his/her residential status for the entire year leading up to program entry. Whenever the member changes residential status, it is recorded, allowing the system to determine how effective it is in, for example,



reducing homeless. An example of how these data are reported is shown in Figure 3.

Figure 3

The graph shows that, for the 4,622 members enrolled statewide in the AB 2034 program through January 2006, the number of days homeless that they experienced after being enrolled in the program dropped nearly 73% compared to what they experienced prior to enrollment.

Similarly, Figure 4 compares the pre-enrollment hospital days for all the members who had at least 72 months in the program with their post-enrollment hospital days on a year-by-year basis. The data clearly show that the programs were successful in every year in reducing hospitalizations from baseline and that the overall trend improved year over year.

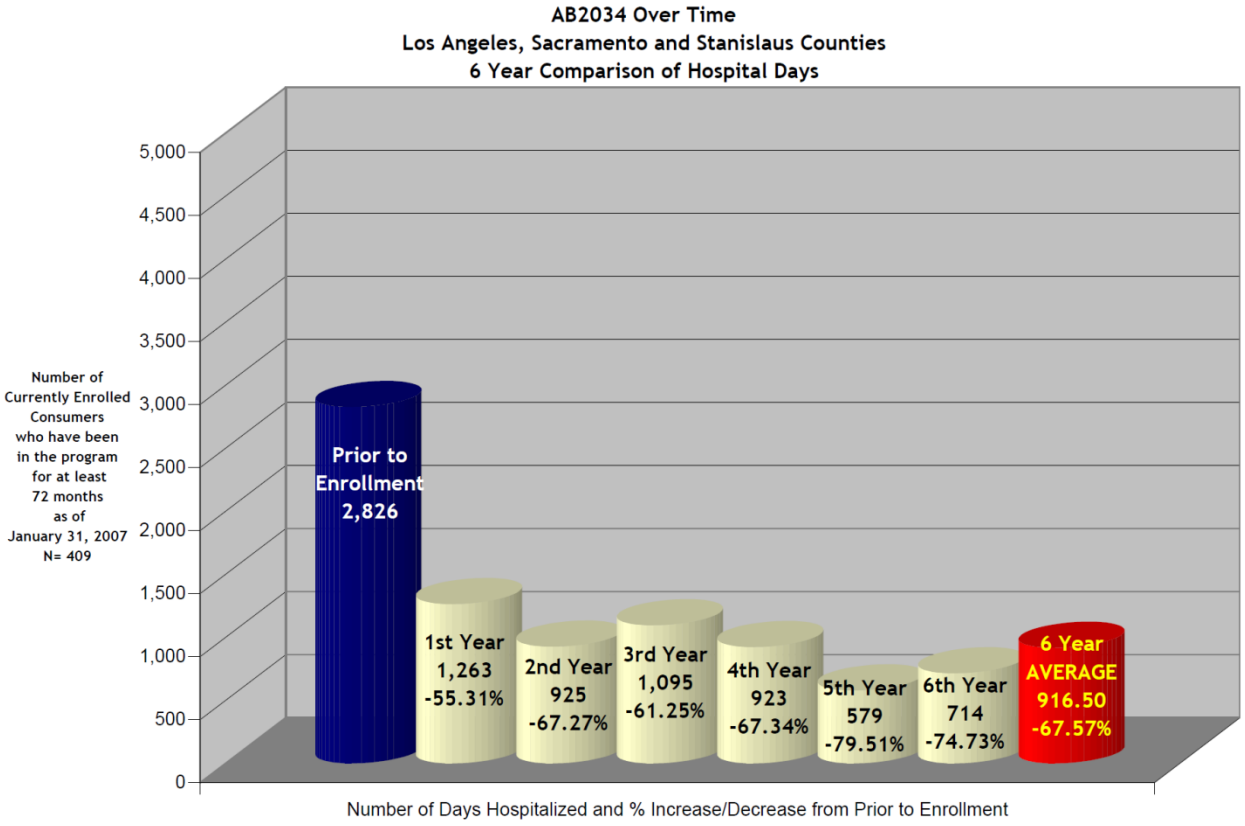


Figure 4

The domains measured by the Key Event Tracking System are extremely relevant to the pilot's goals. For example, tracking the residential, incarceration, and hospitalization statuses of our members will enable us to evaluate our ability to help them maintain HOME & HEALTH. Similarly, tracking their status in regard to employment and educational will provide valuable information regarding our ability to achieve and maintain PURPOSE in their lives. We also intend to make some technological changes

(See Technology Section) to make the system more responsive to staff and easier for staff to use.

However, while the large epidemiological indicators of homelessness, hospitalization and incarceration rates address the "risk" components of our members' lives, with the exception of employment and education rates they do little to inform us about our effectiveness in addressing the "meaning and belonging" parts of our members' lives. They are especially unhelpful in showing whether our services are effective in helping members to develop social connection and community belonging. Additionally, they provide no information or direction at the individual staff-member interaction level regarding whether the member is acquiring the skills and supports that will enable them to achieve "a place to live, something to do, and a person to love."

To remedy this lack, we propose to implement a two-component system of "micro indicators" that are designed to measure our system's effectiveness in helping our members to develop the skills and the supports that they need to live in the larger community. Similar to the process monitoring indicators of Innovation #1, the characteristics of the outcome tracking system should include the following:

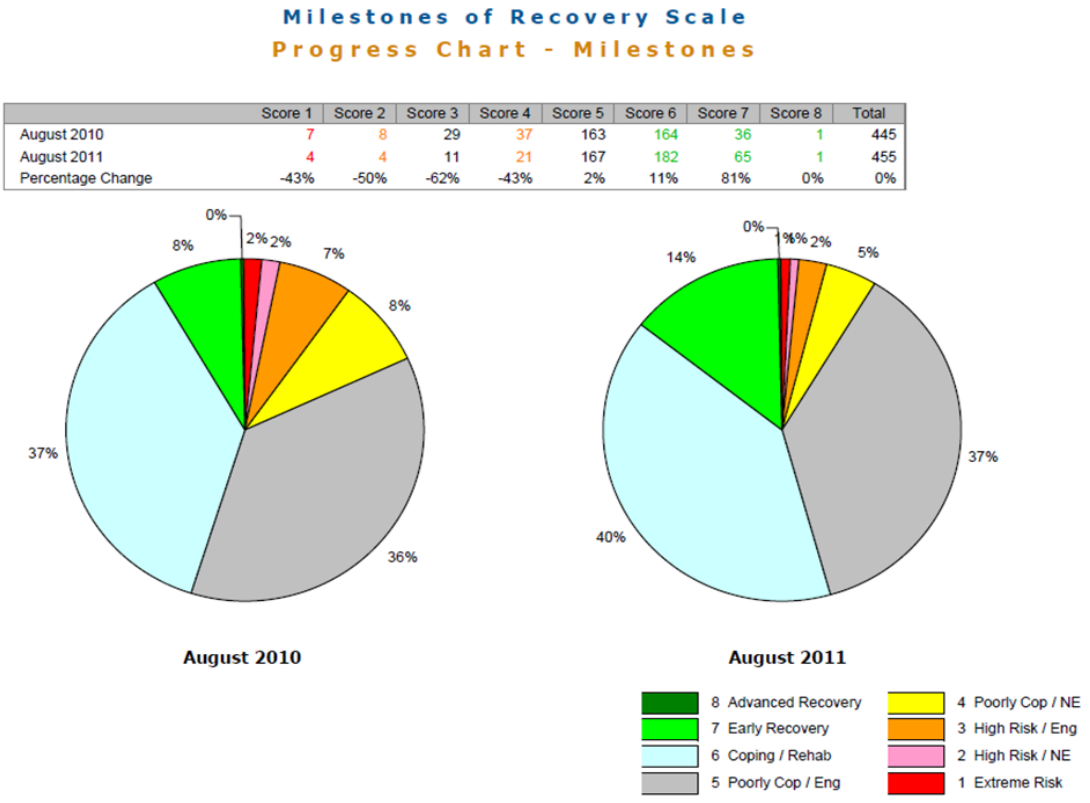
- Outcome indicators that are meaningful and understandable for all stakeholders in the system: members, direct service staff, supervisors and middle-level management, executive leadership, elected officials and funders, and the public at large.
- Outcome indicators that are sensitive to and responsive to the actions taken by staff in their interactions with members.
- Outcome indicators that trace and are consistent with and specific enough to reflect the individual member's "recovery journey" and provide direction to staff as to whether interventions are working.
- Outcome indicators that reflect the needs and goals of the whole person.
- A system that requires no more than 5% of the individual staff person's time to be spent on documentation and evaluation.

The two components of this system are the Milestones of Recovery Scale and the Determinants of Care.

The Milestones of Recovery Scale (MORS) is a valid and reliable one-page, single score assessment that takes just two minutes to complete. It quantifies the stages of an individual's recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. The MORS is rooted in the principles of psychosocial rehabilitation and defines recovery beyond symptom reduction, client compliance and service utilization. It operates from a social psychological perspective which sees meaningful roles and relationships as the driving forces behind achieving recovery and leading to a fuller life. (See Appendix 2 for an example of the scale)

The MORS is the ideal instrument to enable us to evaluate our system's effectiveness in helping members to achieve the goals of LOVE & BELONGING and PURPOSE. Indeed, the scale describes an individual as being in "early recovery" in the following manner:

> These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.



Note that, while there is certainly a component of HOME & HEALTH included in this

Figure 5

definition of recovery, it places at least as much emphasis on the importance of the presence of a social network (LOVE & BELONGING) and the presence of meaningful roles in the larger community (PURPOSE).At admission and every month thereafter, every member is given a rating by a staff person who knows the member well enough to make an accurate rating. For example, most members who are homeless would be rated Experiencing High Risk, Not Engaged (MORS-2) when the mental health system first encounters them. Over time, we would expect the ratings of individual members to go up as they proceed in their recovery journey. The goals is for every member to reach the milestone of Advanced Recovery and by collecting these data we are able to evaluate our system's effectiveness in accomplishing this.

Figure 5 above is an example of how the MORS data can be used to determine program effectiveness. It shows the aggregate MORS ratings for 455 members and how they shifted over a 1-year period. The data show consistent reductions in the number of members at the lower milestones (1-4), almost no change in the number of members rated at milestone 5, increases in the number of members rated at milestones 6 and 7, and no change at milestone 8. Having ongoing MORS ratings on every member in your caseload/agency/system gives you a multitude of ways to ask the question, "How are we doing?"

For example, how many people who are at High Risk/Unengaged (MORS-2) when we first meet them on the streets are we able to help get to Early Recovery (MORS-7)? On average, how long does that process take? Why was one program able to accomplish this in 18 months on average, when it takes another program 2 years? But most importantly, it allows us to answer the question of whether we are helping members to live a life of meaning in a supportive community of their choosing.

<u>The Determinants of Care</u>

Compared to the general population, people with severe and persistent mental illnesses receive disproportionate amounts of healthcare because of their multiple co-morbid conditions and their relative inability to self-coordinate their care. It is clear that an individual's ability to "self-coordinate" is significantly related, if not critical, to his/her ability to achieve positive health outcomes. It is also clear that health outcomes will not improve unless we work with our members to improve their ability to self-coordinate or, failing that, to help them to acquire either natural supports or professional care coordination services.

As mentioned earlier, one of the underlying constructs of the MORS is the member's *general* level of skills and supports. The purpose of the Determinants of Care is to "unpack" this dimension and provide greater specificity as to which domains the

member is able to self-coordinate and the domains for which s/he needs either natural or professional support. The determinant domains are the "actionable behaviors" that staff help members to acquire so that they can live a fuller life in the community. Clinical staff have reported that they have found the determinants to be quite helpful in directing their care and interventions with their members.

The determinants are structured as a binary choice for the staff person to assess whether the member is self-coordinating or needs support in the following domains:

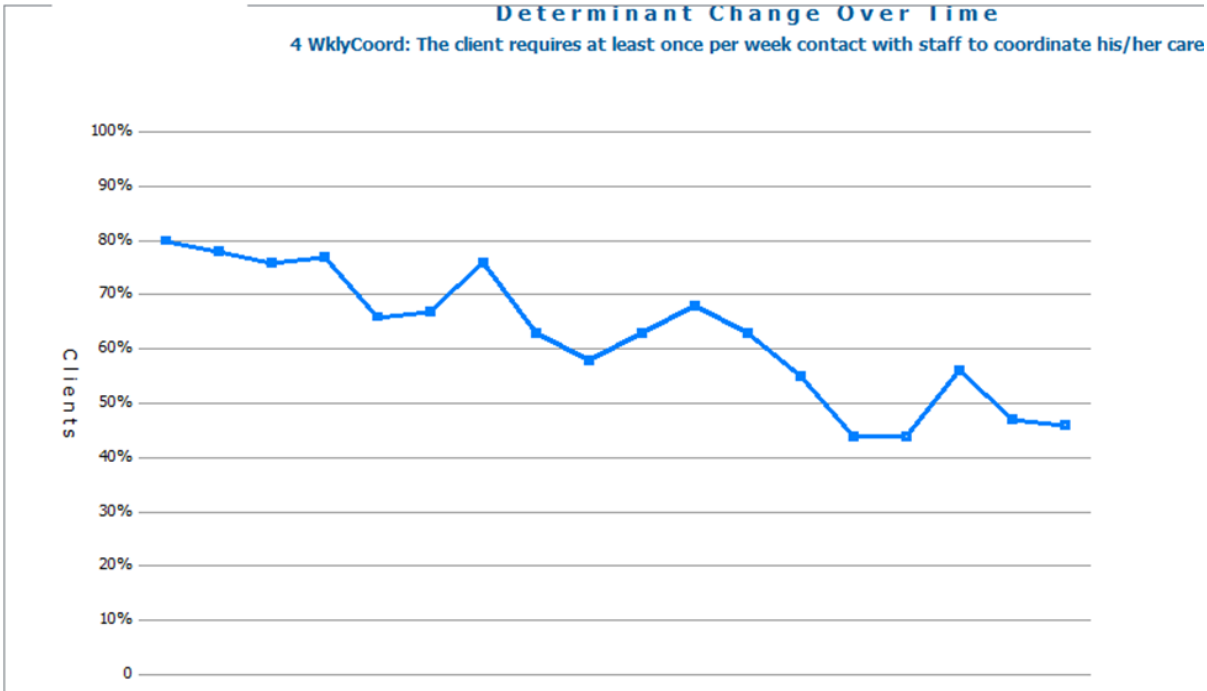
Does the client…

1. …require staff support to manage his/her own financial resources?
2. …require staff support to coordinate his/her own transportation needs?
3. …require staff assistance with 2 or more Activities of Daily Living?
4. …require at least once per week contact with staff to coordinate his/her care?
5. …require staff support to manage his/her medication?
6. …require staff to manage community relations and minimize disruptive behaviors?
7. …show less than 6 months stability at his/her current level of recovery?
8. …require CSS (Flex) funds to meet basic needs (housing and food)?

Every member is assessed monthly and receives a "Determinants Profile" based on whether the answer to each question is positive (i.e., the member needs staff support) or negative (the member does not need staff support). The greater number of positive determinants, the greater the member's need for care and support. Over time, it is expected that the number of positive determinants will decrease as the member learns to self-coordinate various domains in his/her life. Programs, agencies and entire systems can evaluate their effectiveness in helping their members to become more self-coordinating, which in turn is expected to help the member to live more successfully in the larger community.

Figure 6 demonstrates how a program or agency can evaluate its ability to help its members become more self-coordinating. It shows the data over an 18-month period for the percentage of members who "require at least once per week contact with staff to coordinate his/her care."

Determinant Change Over Time: Weekly Care Coordination



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9	Mo 10	Mo 11	Mo 12	Mo 13	Mo 14	Mo 15	Mo 16	Mo 17	Mo 18
4 WklyCoord	148	133	118	113	92	77	71	53	40	39	38	32	21	14	12	15	8	6
Total	185	171	155	146	139	115	93	84	69	62	56	51	38	32	27	27	17	13
Percentage	80%	78%	76%	77%	66%	67%	76%	63%	58%	63%	68%	63%	55%	44%	44%	56%	47%	46%

Figure 6

In this example, 80% of the members required this support from staff at admission to the program. Over time, the number of members requiring at least once-per-week contact gradually decreases until it is at 46% for those members who have been in the program for 18 months.

Essentially, the steeper the slope of the line from upper left to lower right, the more effective (faster) the program/agency/system is in helping its members to improve the particular determinant being considered. This kind of trend data is available for all the determinants and is invaluable for informing us regarding our ability to help our members become more self-coordinating. Combined with the MORS data, they provide all the data we need to determine if the people we serve are indeed recovering.

Summary of the Recovery-Informed Tiered Case Rate / Process Tracking / Performance Measurement System

We believe that, taken together, Recovery-Informed Reimbursement (Innovation A), Recovery-Informed Documentation and Process Monitoring (Innovation B),and Recovery-Informed Performance Measurement (Innovation C) have the potential to revolutionize the delivery of mental health services in Los Angeles County and ultimately across the United States. The advantages of such a system include:

- Process and outcome indicators that are intuitive and understandable by all levels of stakeholders.
- Process and outcome indicators that incentivize staff to focus on the "whole person."
- Process and outcome indicators that prioritize value over volume.
- Minimizing the amount of time staff spend documenting the care they provide and thus increasing the time available to actually provide care.
- Increasing staff morale by insulating them from the financing of services and allowing them instead to creatively and flexibly provide the care that members need.

These innovations are absolutely essential to create the reimbursement, administrative, and regulatory environment in which a recovery-based can exist and thrive in the U.S. With these innovations in place, it is likely that other resource and cultural changes could be considered and implemented. It is to those possibilities that we now turn.

INNOVATION D: The Proposed Service Array: Shifting the Balance from "Illness-focused" Services to "Well-being-focused" Services

The foregoing discussion focuses heavily on the pilot's intended changes to the payment, documentation, and accountability systems currently in place (Innovations A, B, and C). We believe that without these "infrastructure" changes, real mental health system reform in the shape of improved outcomes and increased stakeholder satisfaction will be impossible to achieve. However, we also believe that these changes, while necessary, are insufficient in and of themselves. When we free our direct service staff from their current documentation burdens and give them the opportunity to embrace their most recovery-oriented inclinations, our system must still provide an array of services that will empower members to invest in their own recovery and achieve the goals of "somewhere to live, something to do, and someone to love."

It should be pointed out up front that it is our belief that there is no new, "silver bullet" service that has been missing from the current service array which, if added, would suddenly result in improved outcomes. Rather, we believe that our system must shift its emphasis away from providing illness-focused services and move toward providing trauma-informed, culturally competent and wellbeing-focused services. We will examine this issue in much greater detail below.

It is also important to recognize that every mental health system is actually comprised of *two* parallel service continuums. First, there is the "normal," ongoing system that participants access on a day-to-day basis for regular, non-urgent services. These services include transitional residential placements, traditional clinics offering ongoing therapy and service coordination, wellbeing centers, drop-in centers and clubhouses

offering recreational and social support, and psychosocial rehabilitation services such as supported employment and supported education. There is also the second continuum of care that consists of crisis or urgent care services. This continuum typically includes psychiatric mobile outreach and assessment, mental health urgent care centers, respite and crisis residential programs, emergency rooms and psychiatric hospitals. The second continuum could also be seen as including the services that are primarily characterized by the connection between mental health and law enforcement/criminal justice; namely, jail mental health and the mental health court system (see Figure 7 below).

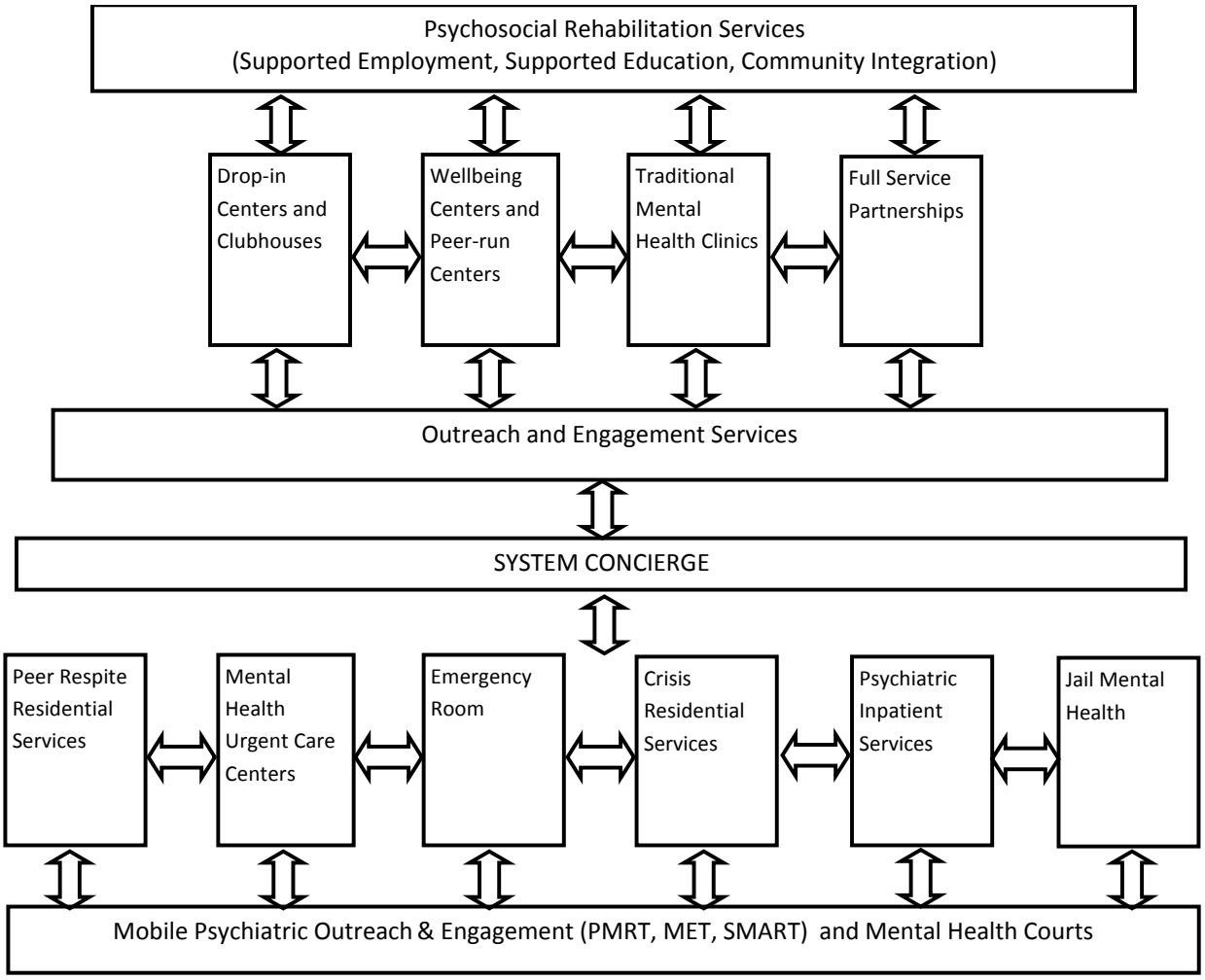


Figure 7

Figure 7 graphically represents the two service continuums as envisioned in the pilot. At the top of the diagram is the routine (non-urgent) service continuum, ranging from drop-in centers and clubhouses to Full Service Partnerships (FSPs). At the bottom of the diagram is the urgent care service continuum, ranging from peer respite residential services to mental health services in the jail. Both continuums are arranged with lower

intensity services on the left and higher intensity services on the right. Generally speaking, the per capita cost of services also increases fairly linearly as utilization moves from left to right.

For obvious economic reasons, nearly all system reform efforts focus on improving access to and increasing utilization of the normal, non-urgent service continuum while at the same time reducing utilization of the urgent service continuum. The pilot is no exception to these goals, which we intend to address in two ways. First, the pilot will explore providing services not currently offered and will improve access to existing services in the non-urgent care continuum. This will decrease the likelihood that members will require urgent care services. In this endeavor, our fundamental assumption is that improvement in mental health status – and its attendant reduction of the need for urgent care – cannot occur "in a vacuum." People will be much less likely to access the urgent care system when they have a life in the community that is not defined by their mental illness. It is for this reason that psychosocial rehabilitation and community integration services are placed at the top of the diagram with access points at all levels of care – it is these services that help people to "get a life."

Obviously, we will never be able to totally eliminate all behavioral health crises. But one of our fundamental tasks will be to examine the ratio that currently exists between "illness-focused" and "recovery-focused" services with the aim of shifting the balance as much as possible toward growth and recovery-oriented care.

Secondly, within the urgent care continuum, we need to improve services at the outreach and engagement end of the spectrum. The mental health system in Trieste appears to have been able to accomplish this to a large degree and has virtually eliminated involuntary hospitalization. One of the major challenges of the pilot will be to improve and enhance the services at the (left) end of the urgent continuum before a crisis situation has progressed to the point where either involuntary hospitalization or incarceration become the only alternatives.

It will also be important to examine the connection points between the non-urgent and urgent service continuums. Interviews with various stakeholders suggest that a lack of communication and coordination between these two systems is at least partially responsible for much of the dissatisfaction with the current system expressed by both members served and other stakeholders. The pilot will introduce a new system-wide function, which we call the System Concierge, whose main goal is to reduce system fragmentation and improve communication and collaboration across system entities.

In summary, the diagram illustrates three important characteristics of the service array as envisioned in the pilot system. First, the diagram shows that non-illness centered, recovery-focused ***psychosocial rehabilitation services*** are envisioned as being primary and available regardless of the member's current level of need. Secondly, ***the***

outreach and engagement function for both continuums of care is viewed as a system function that may or may not be embedded within a particular level of care. (Currently FSPs are the only level of care that is required to provide this function as part of its services). Finally, we will propose the creation of a new pilot-wide function that we refer to as the ***System Concierge***, whose role is to serve as the "glue" between the two continuums of service and ensure that participants do not fall through the cracks. Each of these three elements will be explained in detail below.

A Place to Call Home: The Central Role of the Health Home and Service Coordination

Home is where, when you go there, they have to take you in.
- Robert Frost, "Death of the Hired Man"

Since the passage of the Affordable Care Act, the concept of the "health home" (or "healthcare home") has become increasingly popular as a means for organizing the way healthcare is structured and delivered. Tom David (Health Affairs, February 2012) offers the following description of a health home:

> … health home[s] …offer a more expansive view of health promotion and improvement than more physician-centric medical home concepts. Such projects also acknowledge that medical care alone will be insufficient to ultimately achieve health equity for underserved populations. Patient and family engagement and self-management are seen as essential complements to clinical interventions. A health home prioritizes the voice of the patient and sees culturally sensitive prevention and primary care as the cornerstone for an integrated system of care. (David, 2012, p.1)

Within the pilot's non-urgent, normal continuum of care, the most foundational service offered in the pilot will be to act as the member's health home in which both the mental and physical healthcare needs of the member can be addressed. Members will be assigned to a health home that reflects and is congruent with their level of need and their ability to self-coordinate their care (see the description of the multi-tier case rate system on pages 18 – 20). Wellness and Peer-Run Centers, Outpatient Clinics and FSPs could all serve as the health home for the member, with each of these levels of care providing the appropriate (i.e., needed) amount of assistance for the member to achieve the maximum level of independence in the community.

Having the capacity to address the member's physical healthcare needs is particularly important for the population of people with severe and persistent mental illnesses, who research has shown are likely to die from treatable chronic illnesses as much as 25 years earlier than the general population. There is also much anecdotal evidence to suggest that our population does not always feel welcome at standard community

health clinics and that those clinics may sometimes fail to serve them optimally. This does not necessarily mean that we must offer physical healthcare services directly, but at minimum it means acting as an advocate and a guide for members in their interactions with the physical healthcare system.

Among the population served by the public mental health system, we believe that there is a greater need for case management services than for therapy. While nobody is suggesting that therapy is not helpful for the public mental health population – especially in those cases where the member has experienced significant trauma – we believe that the current balance of those two service modes is not optimally matched to the needs of the population we are serving. As mentioned earlier (Table 2, page 15), one of the most significant differences between the distribution of services provided to members of the Village ISA and the members of the comparison group was the provision of case management vs. psychotherapy. The Village ISA had a ratio of case management to therapy of approximately 8:1 while the staff serving the comparison group members actually reversed that relationship with a therapy to case management ratio of approximately 2.3:1.

As a first step in the implementation, the pilot will examine the ratio of psychotherapy to case management services that currently exists in the pilot region with the aim of assessing whether that balance meets the need of the target population. The health home must ensure that the member has access to needed resources by acting as a broker on behalf of the member and by coordinating services and relationships with other systems and the community at large. But the health home must foster a deeper, more hands-on relationship that recognizes that members often need training in life skills and ongoing, permanent support in some areas of their life. The staff of the health home should see their roles as helping the member to develop the skills to become self-coordinating or, failing that, to help the member put in place the supports s/he needs to live as independently as possible in the community.

The following is a partial list of the life skills that the health home is responsible for helping a member to improve:

1. Managing medications
2. Managing money
3. Managing public transportation
4. Managing community relations (e.g., landlords, neighbors)
5. Managing activities of daily living (e.g., housekeeping, meal preparation, shopping)

Most people would agree that mastering these skills is strongly positively correlated with our ability to enjoy a decent quality of life, regardless of whether or not we have a mental illness. For this reason, one of the central functions of the health home must be

to provide members with the instruction, either individually or in groups, that will enable them to learn these skills to the extent of their choice and ability.

Members who have a higher level of need – such as those in an FSP – would be eligible to access any of the services at the lower, less intense levels. For example, an FSP or Wellbeing center member may avail themselves of services in a drop-in center or clubhouse. On the other hand, a member who has a job and is completely comfortable with and able to navigate physical healthcare services at her local community clinic may only want to receive mental healthcare services such as outpatient therapy at the Wellbeing center serving as her health home.

Getting a Life: The Role of Psychosocial Rehabilitation Services in achieving LOVE & BELONGING and PURPOSE

While it is certainly important to help members lessen and/or eliminate their skill deficits, it must be pointed out that this is not done as an end in and of itself. Rather, the ultimate goal is provide opportunities for members to leverage their new skills in the service of "having a place to live, something to do, and someone to love." While psychotherapy and medication support are often necessary components, we believe that they are insufficient by themselves to enable many of our members to make the leap to community employment or find new friendships and intimate relationships. They need services that are specifically designed to assist them in these endeavors.

To address these needs, the pilot system intends to offer access to a full range of psychosocial rehabilitation services such as supported employment and supported education. Participants across the continuum will be able to make use of these services regardless of their current level of care.

The support and involvement of the larger (i.e., non-mental health) community will be crucial in this endeavor. In Trieste, members of the general community are nearly always supportive of the mission and programs of the mental health system. They seem to take pride in the "model status" of the city's mental health system and show little of the stigma and NIMBYism that seem so prevalent in the U.S.

The pilot intends forge a similar culture by leveraging existing relationships with the Hollywood business community to create a varied "menu" of employment opportunities such as short-term jobs in the community that connect members wanting temporary work with those in the community that seek day laborers. We will hire job developers and job coaches to help members both find and maintain longer term employment and career opportunities. Relationships will be developed with Los Angeles City College to assist members in exploring higher educational opportunities.

There is a great deal of evidence that social isolation and boredom have a significant detrimental impact on the population in general, let alone the population of people with

severe and persistent mental illnesses. To address this issue, the pilot will invest heavily in the enhancement of social and recreational opportunities for members. This will include the hiring of "community integration specialists" whose main role will be to serve as coaches to assist members in forging social support in the larger (non-disabled) community. Service hours will be expanded to include evenings and weekends to provide opportunities for community integration such as sporting events, picnics, yoga classes, etc.

The increased focus on social and recreational opportunities is an ideal opportunity to include the presence of peer supporters in the service mix. Tribe members reported that one of the social cooperatives in Trieste employed peers (along with non-peers) to act as service providers to peers with greater levels of impairment. This type of service, providing an opportunity for members to "give back" as they advance in their recovery, would seem to offer enormous opportunities for meaningful roles and will be given significant consideration for inclusion in the pilot.

In essence, the pilot intends to reverse the usual emphasis between clinical and psychosocial services by making the psychosocial services "primary" and the clinical services "ancillary." While we of course recognize that many of the members we serve require very high levels of traditional clinical services and supports (e.g., therapy, medication support), we also believe that we must constantly remind ourselves of and focus on the whole life the member is trying to lead in spite of having a severe and persistent mental illness. It will be the extensiveness and robustness of these psychosocial, non-illness centered services that will to a large degree determine our success in this endeavor.

Radical Welcoming: Re-envisioning Outreach and Engagement

It could be argued that the greatest challenge our current mental health system experiences is when we try to engage some of the most vulnerable and difficult to serve members of our community. Our response to individuals who refuse services has been to expand involuntary treatment outside of the hospital/inpatient setting in the form of Involuntary Outpatient Treatment (IOT). In contrast, the system in Trieste has virtually eliminated involuntary treatment. The book describing the Trieste system of care – entitled "Freedom First" (Muusse and van Rooijen, 2015) – makes the point that:

> In Trieste, it is therefore a recurring, conscious decision not to lock up people: "open doors" at all time. To the…policy aim of reducing the hospital capacity and building a good support system in the community, a third mission emerges: reducing coercion in treatment, seclusion and long stay (closed doors). Shaping good 'time-out'-facilities where people can be admitted in times of crisis, when outpatient counseling and (intensive) treatment (temporarily) is no longer sufficient, should be a focus point as well. (page 9)

Of course, there are significant differences between Los Angeles and Trieste that would make it difficult if not impossible to perfectly duplicate the Trieste model even if that were desirable. For example, there is no significant homelessness problem in Trieste and therefore their system rarely has to struggle with the difficult question of how to treat people with limited capacity who are living in dire straits on the streets. But it cannot be denied that in some way the mental health system in Trieste has made the services more inviting in a way that significantly reduces the need for involuntary treatment.

Non-urgent Outreach and Engagement – Leveraging Low Demand Services

The first step in making our services more inviting is to expand the variety and accessibility of low-demand psychosocial rehabilitation services as described above. Drop-in centers and clubhouses are a proven means of increasing members' willingness to engage with the system and invest in their own recovery. Even more "advanced" services such as supported employment and supported education can serve as outreach and engagement tools by fashioning them around where the member is in the recovery process. For example, participation in temporary labor pools, sometimes referred to as "work for a day," can be used to provide homeless members with the opportunity to increase their income. Similarly, potential members could be invited to participate in social and recreational opportunities like a picnic or a sporting event. All of these situations provide opportunities for staff to build rapport with potential members even though they have previously refused services or have otherwise failed to establish their health home.

In essence, the pilot intends to re-envision outreach and engagement as a system function that extends across all levels of the non-urgent continuum of services rather than each level of service having its own outreach and engagement team. The Outreach and Engagement Team would be operated with staff from all levels of care who would work together to determine potential members' appropriate level of care. The team would be comprised of staff who could assess "target" (potential) members at all levels of need. Thus, the team would need a nurse to be able to assess the potential member's physical healthcare needs. Similarly, a Peer Advocate with extensive knowledge of social and recreational opportunities in the pilot region would make a valuable addition to the team by being able to connect potential members with referrals/connections to social and recreational opportunities that match the member's desires.

The team would be physically housed in the Clubhouse/Drop-In Center level of care. We envision the Drop-In Center serving as a low-demand "first introduction" setting for the potential member in which the staff could conduct their assessment over a cup of coffee and minimize fear and resistance on the part of the member. The team would

also explore the expansion of its service hours to include the evening hours (5 pm to 11 pm) as a way of offering more normalizing community integration activities.

Urgent/Crisis Outreach and Engagement

As mentioned earlier, one of the common themes among members of the Tribe was how impressed they were with both the availability of mental health staff for "off-hours" crisis and urgent care situations and the lack of need for the involvement of law enforcement personnel in those same situations. In Los Angeles, as in most mental health systems in the U.S., after a certain hour crisis and emergency calls go through our 911 system and law enforcement personnel respond to the call. In the pilot system, we intend to implement a two-pronged effort to improve the system's response to off-hours crisis and emergency calls:

1. expansion of the availability of mental health staff for true 24-7 response to mental health crises, and
2. expansion of and increased access to the lower intensity end of the urgent care continuum (peer respite services, mental health urgent care centers and crisis residential services) to reduce utilization of emergency rooms, hospitals and the jail.

In stakeholder discussions with both law enforcement and fire department personnel, a great deal of frustration was expressed by first responders regarding the lack of alternatives to emergency rooms and involuntary hospitalization. To address this need, the pilot system proposes to fund 10 Peer Respite beds (up to 2-week stay), 10 crisis residential beds (up to 2-week stay), and 10 Behavioral Health Urgent Care "slots" (up to 23-hour stay). These services will undoubtedly reduce emergency service and acute inpatient utilization and also reduce the burden on law enforcement and EMT personnel.

But in addition to these new service functions, the pilot also intends to test a level of service that we are calling "comfort care." Our current crisis response system tends to take a binary approach: The member in crisis has the option of either being hospitalized or evaluated as not needing hospitalization and therefore receiving no care whatsoever. First responders report many situations in which they respond to calls where the member is in a "grey" area where their condition is serious but not posing an immediate psychiatric or medical danger. In these situations, the member often refuses treatment, preferring not to be taken to a hospital emergency room for evaluation. The pilot intends to expand its outreach and engagement team to include a "street medicine" component which would enable the team to receive a "hand-off" from the EMTs to address non-emergency medical conditions and transport the member to a much more welcoming setting like an after-hours clinic, drop-in center, or peer respite program.

While the usual "default response level" to crisis calls will include only mental health staff, law enforcement and mental health staff will need to establish a system in which

they can agree on the criteria for determining those situations in which law enforcement personnel are needed for safety reasons. Procedures will need to be established that allow mental health staff and law enforcement staff to communicate quickly and seamlessly when the need for collaboration arises.

Addressing System Fragmentation: The System Concierge

Every mental health system is a complex collection of various specialized services. This has become even more true over time as the philosophy of treatment for people with severe and persistent mental illnesses has evolved away from simply treating the illness and chosen instead to address the individual's entire life, including their housing, vocational, social, legal and even spiritual goals. This ever-increasing complexity often has the unintended consequence of requiring participants to learn to navigate multiple systems and their various cultures and requirements. While this can be a daunting experience for anybody, for people with severe and persistent illnesses – who are also negatively impacted by the social determinants of health – it can be so discouraging that they either never engage with the system or they quickly give up trying to access our services.

Systems generally address this issue in two ways. First, as mentioned earlier, the health home with its focus on service coordination is critical in helping members to navigate our complex systems of care as well as helping them to access community resources. Second, to the extent possible, agencies and organizations have attempted to create "one-stop-shops" in which a variety of services (e.g., mental health, employment, housing) are available to minimize the number of different bureaucracies that the member must navigate to meet their needs. With its focus on health homes, service coordination and psychosocial rehab services, the pilot system will employ both of these approaches to maximize the possibility of successful engagement. But the pilot also intends to introduce and test a new service function designed to serve not only as a bridge between the different levels of care, but more importantly as a bridge between the non-urgent and urgent continuums of service. We refer to this function as the System Concierge.

The System Concierge is envisioned as having two roles: advocacy and monitoring. In its advocacy role, the System Concierge will serve as an "ombudsman" for members and other stakeholders – particularly family members – who might believe that their loved one is receiving inadequate attention or care. The intention is to create an independent third party to serve as an "honest broker" between the member/member's family and the program that has been assigned as the member's health home. In those cases where the individual has not accepted services and/or has not been assigned to a health home, the System Concierge will work with the system's outreach and

engagement team to make members and their families aware of the service options available to them and help them explore what might be the best service fit for them.

In its monitoring role, the System Concierge will be responsible for tracking all transitions between the non-urgent and urgent continuums of care. This is particularly important when members move from high-intensity inpatient or jail settings back into the community. Unless the member is already enrolled in an FSP with its more intensive follow up after hospital discharge, they often fail to follow through on an initial referral or re-connect with an already established community-based program. The System Concierge will therefore need to have access to all hospital admission and discharge data as well as all jail mental health booking and release data to ensure that participants are not falling through the cracks. Using these data, the System Concierge will be responsible for following up with members recently discharged from the hospital or released from jail to ensure that they are engaged with the system.

The system in Trieste is characterized by extremely open communication between staff and their clients' family members. The "default setting" on communication with family members in Trieste seems to be that it is okay unless the client specifically objects (i.e., opts out), whereas, the default setting in the U.S. is that communication cannot occur unless the client specifically allows it (i.e., opts in). Indeed, the Trieste staff seem mystified by our HIPAA regulations and couldn't imagine a system that was so limiting of their ability to communicate with the family of the person they were serving. Through the function of the System Concierge, the pilot intends to explore how our system can include family members more effectively and humanely in the service delivery process while still respecting the civil rights of the members being served.

INNOVATION E: Technology that supports documentation, accountability and payment reforms

The Documentation/Accountability/Reimbursement system proposed in Innovations A – C will require a significant investment in technology to realize its potential to reduce the documentation burden on staff. We envision a HIPAA-compliant electronic health record that is accessible through a smart phone application. Staff will record not only their interactions with individual members but ALL the activities in their work.

For example, when the direct service staff leaves the facility to conduct an outreach visit to a homeless encampment, the staff will say "Begin drive to visit John Doe at homeless encampment." The application will then automatically record the amount of time that the staff spends on the road until the staff says, "Arrived at destination." When the staff actually begins the interaction with the member, s/he will simply say, "Talking with John Doe" and the system will record the amount of time spent with John Doe up until the time the staff says, "Concluding conversation with John Doe." The application will then report the amount of time spent in the interaction and will ask the staff to apportion the

time according to the quality of life domains discussed (Innovation A, component 1) and the type of service provided (Innovation A, component 2) during the interaction with the member.

Data will be entered into the EHR database either wirelessly or when staff return to the facility and dock their phone with the system.

It is expected that this voice-enabled system will reduce keyboard data entry by as much as 90% and thereby reduce the data entry time for staff by several orders of magnitude. It also has the benefit of being much more accurate and reliable in that it requires staff to enter their documentation on an ongoing, real-time basis.

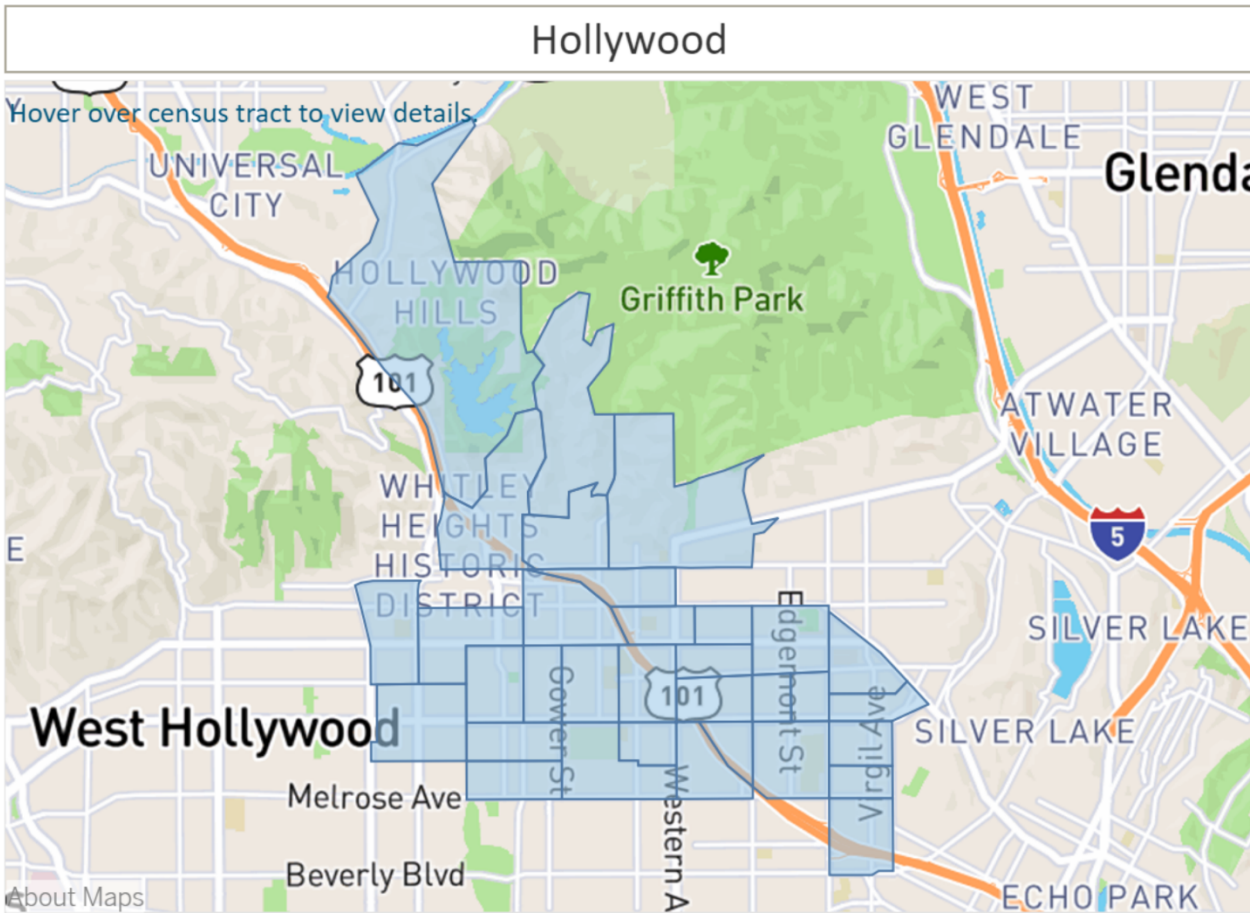
PROPOSED PILOT REGION AND POPULATION

While our ultimate aim is to transform the entire Los Angeles County mental health system, this proposal will define a specific region and a specific population within that region to test the assumptions of the model and ultimately demonstrate proof of concept. To that end, the Hollywood area has been selected to serve as the geographic region for the pilot and the population will be defined as all individuals who meet the criteria for specialty mental health services. The population will include both individuals currently receiving mental health services as well as estimates of the homeless population who are not currently receiving mental health services but are likely to need mental health services and who are also already using other county and city services such as health and criminal justice at a greatly disproportionate rate.

The Region

The “Hollywood region” will be defined (consistent with the Los Angeles Homeless Services Authority) as consisting of the following census tracts:

1893.00, 1894.00, 1895.00, 1896.00, 1897.01, 1901.00, 1903.01, 1905.10, 1905.20, 1908.01, 1908.02, 1909.01, 1909.02, 1911.10, 1911.20, 1912.03, 1912.04, 1913.01, 1913.02, 1914.10, 1914.20, 1915.00, 1916.10, 1916.20, 1917.10, 1917.20, 1918.10, 1918.20, 1919.01



The total population for these 28 census tracts is approximately 103,625 (2016 data). A map outlining these census tracts appears above.

The Population

The service population will consist of (1) all individuals 18 years of age and older residing within the above-defined region who meet criteria for specialty mental health services, and (2) individuals 18 years of age and older who do not currently live within the above-defined region but have received mental health or substance use services from a County DMH directly-operated or contract provider between July 1, 2017 and June 30, 2018. As defined, this population will require estimates for the large numbers of homeless individuals living in the region who are likely to experience mental illnesses and/or substance use disorders.

PROPOSED BUDGET and BUDGET NARRATIVE

Introduction

L.A. County leadership realizes and acknowledges that The TRIESTE Project is an unusual innovation request. We are not proposing to implement an already defined new program or practice that will stand alone within the same old system. In essence, we are asking for innovation funding to temporarily replace the entire existing MHSA/Medicaid-based funding system within a specific geographic region to demonstrate how effectiveness and satisfaction can be improved when services are untethered from the current payment and documentation systems. These funds will allow us to engage the local community in a robust stakeholder process to determine what the community actually wants and needs and design a service system that will be more responsive to those needs.

However, because the system is not "pre-determined," it is impossible to explicitly state the positions that will comprise the system and their full-time equivalencies. While there will certainly be social workers and psychiatrists, there is no way of knowing in advance how many there will be. Similarly, there are no job developer positions within the current pilot region, but if the system moves in the direction of providing supported employment services, then almost certainly these positions will come into existence. But it is impossible to estimate the FTEs until the stakeholder process takes place.

Because of this, our proposed budget makes some assumptions about allocations to certain categories. Our first assumption is that 65% of the budget of any mental health system will go to personnel costs, including both salaries and the employee benefit/tax burden package (e.g., health care benefits and employer's tax burden). For the purposes of this budget, we have assumed that the benefit/tax burden package for employees is 40%. So, for example, a staff person earning $50,000 per year would have a benefit/burden package of $20,000 for a total compensation package of $70,000. This is reflected under "direct costs" on line 2 of the attached budget.

Our second assumption is that our administrative overhead rate is 15% of the overall budget. This allocation appears in lines 3,6, and 12. We have allocated this cost in proportion to the expenditure to which the administrative overhead is attached. So, for example, 65% of the total administrative overhead for the system is allocated to personnel, because that is 65% of the overall budget.

While we believe that our allocations are well-grounded and reflect the realities of current mental health programs, should the TRIESTE project proposal be granted funding, we are also requesting that we be granted some flexibility in percentages we ultimately allocate to the different categories. Specifically, we would request a 10% variance (plus or minus) that would give us the authority to adjust allocations should the need arise. For example, if we discovered that our personnel costs were only 58% of our total budget, but our operating costs were higher by a comparable amount, we

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	**535,700**	**10,260,000**	**10,260,000**	**10,260,000**	**10,260,000**	**41,575,700**
2.	Direct Costs	**214,300**	**4,105,000**	**4,105,000**	**4,105,000**	**4,105,000**	**16,634,300**
3.	Indirect Costs	**112,500**	**2,535,000**	**2,535,000**	**2,535,000**	**2,535,000**	**10,252,500**
4.	Total Personnel Costs	**862,500**	**16,900,000**	**16,900,000**	**16,900,000**	**16,900,000**	**68,462,500**
OPERATING COSTS		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 20/21**	**FY 20/21**	**FY 20/21**
5.	Direct Costs	**750,000**	**5,780,000**	**5,780,000**	**5,780,000**	**5,780,000**	**23,870,000**
6.	Indirect Costs	**112,500**	**1,020,000**	**1,020,000**	**1,020,000**	**1,020,000**	**4,192,500**
7.	Total Operating Costs	**862,500**	**6,800,000**	**6,800,000**	**6,800,000**	**6,800,000**	**28,062,500**
NON RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 20/21**	**FY 20/21**	**FY 20/21**
8.	**Facilities/Tenant Improvements**	**4,000,000**					**4,000,000**
9.	**EHR/Comm System Integration**	**3,000,000**					**3,000,000**
10.	Total Non-recurring costs	**7,000,000**					**7,000,000**
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 20/21**	**FY 20/21**	**FY 20/21**
11.	Direct Costs	**2,500,000**	**2,000,000**	**2,000,000**	**2,000,000**	**2,000,000**	**10,500,000**
12.	Indirect Costs	**375,000**	**300,000**	**300,000**	**300,000**	**300,000**	**1,575,000**
13.	Total Consultant Costs	**2,875,000**	**2,300,000**	**2,300,000**	**2,300,000**	**2,300,000**	**12,075,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 20/21**	**FY 20/21**	**FY 20/21**
14.	**Community Resource Dvlpmnt**	**250,000**	**225,000**	**225,000**	**225,000**	**225,000**	**1,150,000**
15.							
16.	Total Other Expenditures	**250,000**	**225,000**	**225,000**	**225,000**	**225,000**	**1,150,000**
BUDGET TOTALS							
Personnel (line 1)		**535,700**	**10,260,000**	**10,260,000**	**10,260,000**	**10,260,000**	**41,575,700**
Direct Costs (add lines 2, 5 and 11 from above)		**3,464,300**	**11,885,000**	**11,885,000**	**11,885,000**	**11,885,000**	**51,004,300**
Indirect Costs (add lines 3, 6 and 12 from above)		**600,000**	**3,855,000**	**3,855,000**	**3,855,000**	**3,855,000**	**16,020,000**
Non-recurring costs (line 10)		**7,000,000**	**0**	**0**	**0**	**0**	**7,000,000**
Other Expenditures (line 16)		**250,000**	**225,000**	**225,000**	**225,000**	**225,000**	**1,150,000**
TOTAL INNOVATION BUDGET		**11,850,000**	**26,225,000**	**26,225,000**	**26,225,000**	**26,225,000**	**116,750,000**

Table 4

would request the ability to shift funds from one category to another as long as we did not exceed the overall budget amount.

Year One Budget (See Table 4 FY 19/20 above)

TOTAL: $11,850,000

Because the first year of the pilot is essentially a planning year, it is necessary to provide a separate narrative for year 1 and another narrative for years two through five when the new system is in place and the services are being provided.

The year one budget focuses on “building the infrastructure” that will be needed to provide the facilities and equipment for staff to provide services under the new model. To that end, $4,000,000 is allocated for the renovation and improvement of facilities intended to provide four new services not currently offered: a 16-bed transitional residence, a 10-bed peer respite service, a 10-bed crisis residential service, and a 10-slot urgent care center.

It is important to point out that these funds will not be used for the purchase or construction of new facilities; they will be used only for tenant improvements on existing properties that will allow the use of the properties for the intended programs.

Similarly, $3,000,000 is allocated for the design and creation of 1) a new electronic health record (EHR) system that will support the new payment, documentation, and accountability systems, and 2) a communication system that allows the integration of police and fire first responder units with the mental health system to improve crisis response.

The first-year budget also includes $2,500,000 for consultation in a wide variety of domains. With the shift from a more medical model to a more psychosocial model, we will be seeking consultation from experts in the following areas:

Overall Coordination/Project Oversight	200,000
Housing	150,000
Community Integration	100,000
Employment	100,000
Performance Measurement	50,000
Legal	200,000
Stakeholder Process Facilitation	200,000
Communication	100,000
Training	650,000
Evaluation	750,000

Table 5

As an example, in all likelihood we will need legal consultation regarding the seeking of waivers from the California Department of Health Care Services to allow us to receive innovation funds instead of Medicaid funds for services that we provide to Medicaid beneficiaries. We have also allocated $200,000 for an outside facilitator to design and lead the overall stakeholder process.

We have allocated $650,000 for the extensive training that we will offer during the first year of the project. Staff will receive training on the use of the new EHR and the new performance measures and how to employ and document them. We also intend to provide specific training in certain evidence-based psychosocial practices such as Individual Placement and Support (IPS) and other practices that will shift the culture toward a more well-being focused approach. We also intend to include trainings for the general community to reduce stigma and increase buy-in.

In year one we are allocating $750,000 for the design and set up of the evaluation that will take place over the 5 years of the pilot project.

We are also allocating $250,000 for community resource development that will allow us to incentivize faith organizations and businesses to offer opportunities that are welcoming and inviting to our members and staff and thereby build buy-in from the community.

Years Two through Five Budget Narrative (See Table 4 above FYs 20/21-23/24)

TOTAL: $104,900,000 ($26,225,000 per year for four years)

The budgets for years two through five reflect the relative completion of the stakeholder design process and movement toward the delivery of services. Therefore, the largest expenditure during this period is for staffing, which totals $67,600,000 over the four-year period ($16,900,00 per year). (As stated in the introduction, our assumption is the 65% of the budget will be allocated to personnel expenses.

The second largest expense during years two through five is for operating costs, which total $27,200,000 ($6,800,000 per year).

Consultant costs diminish significantly during years two through five, although we still anticipate a total cost of $2,000,000 per year in this category. The major areas of consulting we anticipate are:

Overall Coordination/Project Oversight	200,000
Housing	150,000
Community Integration	75,000
Employment	75,000
Training	500,000
Evaluation	1,000,000

Table 6

Finally, as in year one we are allocating $225,000 for community resource development that will allow us to continue to incentivize faith organizations and businesses to offer opportunities that are welcoming and inviting to our members and staff and thereby build buy-in from the community.

Table 7 below reflects the levels of funding that are allocated for administration ($15.7m) and outside evaluation services ($4.75m) over the life of the project.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
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	390,000	3,675,000	3,675,000	3,675,000	3,675,000	15,700,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**390,000**	**3,675,000**	**3,675,000**	**3,675,000**	**3,675,000**	**15,700,000**
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	**750,000**	**1,000,000**	**1,000,000**	**1,000,000**	**1,000,000**	**4,750,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	**750,000**	**1,000,000**	**1,000,000**	**1,000,000**	**1,000,000**	**4,750,000**
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	**11,850,000**	**26,225,000**	**26,225,000**	**26,225,000**	**26,225,000**	**116,750,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**11,850,000**	**26,225,000**	**26,225,000**	**26,225,000**	**26,225,000**	**116,750,000**

Table 7

Budget Summary

The overall cost of this innovation proposal comes to $116,750,000, of which $4,750,000 is for the cost of the evaluation. Therefore, the five-year total cost of the system design and service package, excluding the evaluation, is $112,000,000.

EVALUATION

Methods

A university-based evaluator will be engaged to independently assess and report on the outcomes of the project. Although it is impossible to conduct an evaluation with random assignment to treatment and comparison conditions, we will do the next best thing. We intend to compare the results and outcomes achieved with the target population in the defined pilot region with a demographically and fiscally similar comparison region and population within Los Angeles County. Using data provided by the CAO's office and the Department of Mental Health, one of the first tasks of the independent evaluator will be to define this comparison population and region. Once defined, we intend to survey and track the population in the comparison region using the same instruments and indicators that will be used with the pilot population (see below). Over the intended four-year duration of the pilot study, we will be able to observe and evaluate three broad questions:

1) Are the lives of the people served by the innovation pilot (members) significantly improved over time across the variety of measures and indicators,
2) Are the outcomes within the pilot population significantly better or worse than the outcomes in the comparison population, and
3) Are the costs of providing services to the pilot population greater or less than the cost of services provided to the comparison population?

Intended Outcomes

The intended outcomes of the pilot fall into seven broad categories:

1) Improved Quality of Life
2) Reduction in Adverse Events
3) Improved Functional Status
4) Improved Member Satisfaction with Care
5) Improved Staff Job Satisfaction
6) Improved Family and Larger Community Satisfaction
7) Reductions in the Overall Cost of Care

The indicators for each of these outcome domains will be described below.

Quality of Life Indicators

In keeping with the goals of helping our members to find PURPOSE and LOVE & BELONGING, quality of life indicators will be an important feature of the evaluation. As described in Innovation C, we intend to use the Key Event Tracking System (KETS) already in use in Los Angeles County and across the state. The two quality of life domains tracked by the KETS that are particularly relevant for our purposes are the Employment and Education domains, which allow us to evaluate our ability to help our members find PURPOSE in their lives. Upon entry into the program/study, all members are administered the KETS and their baseline employment and education statuses for the year prior to enrollment are recorded. While in services, any changes to their employment or education statuses are recorded in real time. These data will give us real-time access to the effectiveness of our services and will allow us to judge our effectiveness over time.

The Milestones of Recovery Scale (MORS) will be the major outcome measure used to evaluate our ability to help members find LOVE & BELONGING. While it is a broad measure of "recovery," there is a very significant component of social connectedness and belonging within the MORS and we anticipate seeing improvements in MORS scores as social connectedness improves. However, we also intend to implement a self-report measure that will provide information from the member's perspective on whether their needs for social connection, love and intimacy are being met. While there are many instruments that purport to measure this, we believe the determination of the specific instrument should be part of the stakeholder process that will occur in the year prior to the actual implementation of services.

Expected results: We anticipate an average 1.5 points-per-year increase in the MORS score across the pilot population vs. an average .75 points-per-year increase across the comparison population.

Adverse Event Indicators

The three primary indicators of adverse events that the pilot will track are:

1) emergency room utilization rates,
2) hospitalization rates, and
3) incarceration rates.

As in the case of employment and education, upon entry into the program, a member's prior year history of use of the emergency room, hospitals and jails and prison are recorded in the KETS. While in services, any use of the emergency room, hospitals or incarcerations in jail or prison are recorded in real time. These data will give us real-

time access to the effectiveness of our services and will allow us to judge our effectiveness over time in reducing these adverse events.

Expected results: We anticipate a 30% reduction in the rate of emergency room visits and hospitalization admissions and days across the pilot population vs. no change in the rates for people served in the comparison group. We also anticipate a 50% reduction in the rate of incarceration days for people served in the pilot vs. people served in the comparison group.

Functional Status Indicators

The primary indicator for the outcome improved functional status will be the Determinants of Care (See Innovation C). The determinants are structured as a binary choice for the staff person to assess whether the member is self-coordinating or needs support in the following domains:

1. Managing medications
2. Managing money
3. Managing public transportation
4. Managing community relations (e.g., landlords, neighbors)
5. Managing activities of daily living (e.g., housekeeping, meal preparation, shopping)

The Determinants are assessed at baseline upon entry into the program and thereafter on a monthly basis. This will allow the pilot to determine its success in helping its members to become more self-coordinating over time.

Expected results: We anticipate a 10% increase per year in the number of members in the pilot who become self-coordinating in any one of the five functional domains vs. the number of members in the comparison group who become self-coordinating.

Member Perception of and Satisfaction with Care Indicators

While there are many consumer and member satisfaction surveys available, we believe that it is essential that we seek stakeholder input to determine the actual instrument we will use. Fundamentally, at a minimum, the instrument selected/created should be able to capture the member's level of agreement with the following three statements:

1) I feel welcomed and respected by staff.
2) I am satisfied with my role in making decisions about my care.
3) I have the opportunity to involve family or other natural supports in my services.

The measure will be administered every 6 months after the member's admission to the program. To increase response rate, it will be available both in paper version as well as on-line.

Expected results: Members of the pilot population will be statistically significantly more satisfied than members of the comparison population.

Staff Job Satisfaction Indicators

As with member satisfaction with care surveys, there are many staff job satisfaction surveys available. As with members, we feel it is extremely important that we seek stakeholder (i.e., staff) input to determine the actual instrument we will use. Fundamentally, the instrument selected/created should embody and reflect the level of staff endorsement of the following four characteristics:

1) Do our staff feel HOPEFUL and understand how our vision and mission resonate with their own personal values?
2) Do our staff ENGAGE WITH THE COMMUNITY in ways that support meaningful community roles for members and themselves?
3) Do our staff feel EMPOWERED to take responsibility and encourage risk-taking among their members?
4) Do our staff feel that they are part of the HEALING process and that they can use their own passions and valuable life experiences to the benefit of their members?

The measure will be administered to all staff on a yearly basis. The results will be used to provide feedback to management staff on an ongoing basis to identify when staff morale is low and provide insight as to how it might be improved.

Expected results: Staff in pilot will be statistically significantly more satisfied than staff serving members of the comparison population.

Family and Larger Community Satisfaction Indicators

To our knowledge, there are few if any standardized measures of family satisfaction with care. As with member and staff satisfaction, we believe that it is essential that we seek stakeholder input to determine the actual instrument we will use to measure family satisfaction with care. Fundamentally, at a minimum, the instrument selected/created should be able to capture the family member's level of agreement with the following three statements:

1) I feel welcomed and respected by the staff who are treating my loved one/family member.
2) I am satisfied and comfortable with my role in providing input and feedback to the staff member(s) providing care for my loved/on family member.

3) I have adequate opportunities to be involved in the provision of care and natural supports for my loved one/family member.

The measure will be available to self-identified family members of the pilot and comparison populations on an annual basis. The results will be used to provide feedback to both direct service and management staff on an ongoing basis to identify when family morale is low and provide insight as to how it might be improved.

Expected results: Family members of people being served in the pilot will be statistically significantly more satisfied than family members of the comparison population.

Similar to the measurement of family satisfaction, to our knowledge there are no measures of the larger community's general level of satisfaction with the mental health system. It is our belief that much of the NIMBY reaction of communities reflects a failure on our part to meaningfully engage with the concerns of the larger community and educate them about our goals and mission.

Therefore, we will engage the larger community of the pilot region in a robust stakeholder discussion about their needs and concerns in an effort to create a standardized survey that will allow us to evaluate our ability to address those concerns.

Expected results: Community members living in the pilot region will be statistically significantly more satisfied with their local mental health system than community members living in the comparison region.

Overall Cost of Care Indicators

The independent evaluator will have access to the cost data for all people served in both the pilot population and the comparison population. These data include not only the cost of outpatient mental health services, but also the cost of physical healthcare services, substance abuse prevention services, emergency room services, hospital services and jail and prison services. We anticipate that it will be a relatively straightforward process to compare the overall cost of services provided to the pilot population vs. the comparison population.

Expected results: If the pilot is successful in its goals, we should see significant reductions in the overall cost of services vs. the comparison population, even if we see slight increases in the costs of some services (such as psychosocial rehabilitation services, crisis residential services or urgent care).

Assessing Ongoing Sustainability

The County anticipates that the pilot will be wildly successful in improving effectiveness, improving satisfaction and reducing costs as described above. However, at a minimum,

the requirement for continuation of the pilot beyond the innovation period (4 years) only requires marginal improvement in outcomes at no increase in overall cost of services. The most difficult potential judgment for continuation beyond the innovation period will be if we are able to achieve significant improvement in outcomes with an attendant slight to moderate rise in the overall cost of services – a result that could occur if we are unable to lower the rate of adverse events such as hospitalization and incarceration. If that were to happen, a judgment would have to be made as to whether the level of improvement in the outcomes justifies the increased level of cost. Assuming positive outcomes from the pilot, the County will make the services an ongoing part of its annual request for MHSA CSS funds and anticipates drawing down matching FFP to serve as the main source of funding in the future.

Proposed Timeline for Implementation – First 20 Months

November, 2018

- Initial draft of concept paper completed

December, 2018

- Determination of the geographic boundaries of the pilot

March, 2019

- "Final" draft of concept paper completed
- Determination of the precise population to be served and initiation of economic analysis of current county expenditures for the population
- Expanded stakeholder process to vet concept paper begins
- Submission of concept paper to MHSOAC

April, 2019

- Initial presentation to members of the MHSOAC

May, 2019

- Submission of full proposal for five-year innovation grant to the MHSOAC with expectation that grant will be awarded to begin effective July 1, 2019 through June 30, 2024.
- Initial discussions/negotiations with potential independent evaluators to determine scope and cost of the evaluation
- Initial discussions/negotiations with potential EHR vendors to determine scope and cost of the new EHR.
- MHSOAC officially awards Innovation Grant (MH Month!)

July 1, 2019 – June 30, 2020

- Securing all necessary regulatory waivers
- Expanded stakeholder process to determine scope and implementation of services
- Selection of independent evaluator and implementation of evaluation protocols
- Selection of EHR vendor and implementation of system
- Initial training of staff on all data collection and accountability systems

July 1, 2020

- Doors open and services begin under the pilot project.

Appendix 1

Recovery-Oriented Service Categories

1. **Welcoming / engagement** – connecting the member with staff, program and peers, relationship building, demonstrating our "usefulness" to the member, engaging in collaborative goal setting, shared decision making, connecting with the member through self-disclosure

2. **Crisis interventions / Responding to basic safety needs and community expulsion threats** – accessing, collaborating with and/or diverting from hospitals and jails, advocating with the legal system to prevent incarceration, locating, placing in and/or paying for emergency shelter to prevent homelessness, safety interventions – medical, substance abuse harm reduction and prevention, responding to threats of dangerousness, suicidality, and impending harm (e.g., domestic violence)

3. **Assessments and planning –** assessing goals and needs, understanding their view of themselves, mental health status assessment, Quality of Life assessment, co-occurring conditions (e.g., medical, substance abuse, developmental disability), "eligibility" determinations (voc rehab, disabled students, SSI, bus passes), fitness determinations (legal competence, child custody and driver's license)

4. **Building and maintaining the safety net / "protective factors"** - assisting in obtaining benefits and entitlements, connecting to poverty services (e.g., COA food bank, multi-service center), charity (e.g., bus tokens, food, clothes, toiletries), safe and secure housing, family connections, assisting in obtaining basic documentation (e.g., ID, birth certificate), connecting to basic social services (DPSS, SSA), connecting to cultural connections, (Native American services, UCC), connecting to spiritual strength and security (faith community)

5. **Motivating / Engaging in growth-oriented activities –** engaging in motivational interviewing, outreaching to isolated members, exposure to opportunities (e.g., plays, sports, dances, hobbies, job fairs, schools), exploration of possibilities for the future, career exploration, core gift activities, goal visualizing, peer bridging

6. **Promoting mental wellness and treating mental illnesses and substance abuse disorders to reduce barriers –** helping members to gain control over

their mental illness, helping members to identify and control their symptoms (e.g., WRAP), 12-step step work, medication services, providing psychotherapy, building emotional coping skills (e.g., CBT, coping with past traumas, anger management, relationship skills), building wellness skills (e.g., meditation, eating and sleeping routines, yoga), treatment of acute symptoms and relapses

7. **Promoting physical wellness and treating physical illnesses** – providing basic wound care, monitoring and treating chronic physical illnesses (e.g., diabetes, hypertension, chronic pain), medication management for physical illness medications, seizure response, physical illness education (e.g., diabetes, hepatitis), smoking cessation, promoting physical wellness (e.g., exercise and nutrition), pregnancy counseling, safe sex counseling

8. **Providing and building support –** connecting to resources (e.g., job development, educational) and community resources (Faith-based Community Center, Gay and Lesbian Center, primary care provider, 12-step support groups, warm lines), connecting to social services (e.g., In Home Supportive Services, Family Preservation), participating together in community activities and opportunities ("giving moral support"), helping families to support members (e.g., family education, consultation, problem solving), providing help directly (e.g., "doing it for them," adding structure to their lives, making decisions for them, "caretaking")

9. **Rehabilitation / Skill building –** teaching, job coaching, supported models (employment, education, housing), in-vivo teaching, providing work experience, teaching self-help skills (e.g., budgeting, shopping, laundry, hygiene, medication management), helping the member to build and practice meaningful roles

10. **Building personal growth and responsibility –** helping members understand and move through normal stages of life (e.g., prolonged adolescence, first parenting, mid-life crisis, empty nest syndrome), building self- responsibility (learning cause and effect, not blaming others), building self- efficacy (building the ability to positively impact one's life), empowering members

11. **Community integration –** developing and facilitating members' connections beyond mental health and social services (taking a member to a Mommy and Me group, helping a member to join a bowling league, creating a calendar of low-cost community events), helping member to discover niches, roles, and opportunities in the community, promoting being a good neighbor and citizen, helping member

to invest in and give to community in positive ways, helping the member to learn to give to others

12. **Community development –** making the community a better place for people with mental illnesses, increasing tolerance and acceptance of mental illness, reducing segregation, reducing stigma, developing welcoming hearts in the community, building connections with other community social causes

13. **Promoting self-reliance, separation from services, and graduation –** building financial independence (getting off SSI and Section 8), obtaining private insurance, preparing for graduation, facilitating relationship changes with staff, finding and providing opportunities to give back to others still struggling, developing self-advocacy skills, developing friendship skills

Appendix 2
Milestones of Recovery Scale

CLIENT NAME: MIS#: PRINT DATE:

RATING PROCESS: ☐TEAM CONSENSUS ☐INDIVIDUAL RATER (NAME:) RATING DATE:

MILESTONES OF RECOVERY SCALE

Please circle the number that best describes the current (typical for the last month) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last ***month***, please check here ☐ and do not attempt to rate the member. Just return the form along with your completed assessments.

1. **"Extreme risk"** – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. **"Experiencing high risk/not engaged with mental health provider(s)"**- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. **"Experiencing high risk/engaged with mental health provider(s)"** – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

4. **"Not coping successfully/not engaged with mental health provider(s)"** – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. **"Not coping successfully/engaged with mental health provider(s)"** – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. **"Coping successfully/rehabilitating"** – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.

7. **"Early Recovery"** – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

8. **"Advanced Recovery"** – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbors.

 Revised 01/10/14

Appendix 3

CURRENT SERVICE UTILIZATION AND FINANCIAL ANALYSIS METHODOLOGY

Producing A Hollywood Baseline County Cost Estimate

The Trieste pilot proposal will draw on analysis conducted by the Clinical Informatics Division within Los Angeles County's Department of Mental Health (CID/DMH) and the Research and Evaluation Services unit within the County's Chief Executive Office (RES/CEO). The analysis will produce 12-month (FY 2017-18) estimates of DMH direct services expenditures, as well as similar direct services spending through four additional Los Angeles County agencies: The Departments of Health Services (DHS), Public Health (DPH), Probation and the Sheriff (LASD). Specifically, these estimates will encompass County service use patterns and frequencies observed for adults using DMH service facilities within Hollywood, California census tracts. These estimates, which are referred to in this discussion as *the Hollywood Estimate*, will establish a comparative reference point against which costs associated with the proposed Trieste pilot can be gauged.

The Direct Services Cost Components of the Countywide and Hollywood Estimates for FY 2017-18*	
Agency	**Direct Services Costs**
DHS	Outpatient, Emergency, Inpatient Treatment
DMH	Outpatient, Crisis Stabilization, Acute Inpatient, Residential Treatment
DPH	Outpatient, Detox, Maintenance and Residential Treatment through SAPC
LASD	Booking Fees, Jail Bed Days, and services provided through the Jail Ward+
Probation (Adult)	Probation Supervision for Adult Felons and AB 109ers**

*In this context, *direct services costs* are simply the cost of services provided directly to individual clients and are not inclusive of administrative overhead or aggregated programmatic costs, estimated proportional distributions of which must be subjected to complex *pro rata* adjustments and assumptions, which are not necessary until they are compared against the pilot group and other populations.

+ The Sheriff's records currently available for these estimates do not include medical and mental health services provided to inmates, except for hospital treatment episodes, which occur through the Jail Ward. Since 2015, medical encounters and episodes in the County's jail system have been administered by DHS's Correction Health division. Utilization data for Correctional Health may be available for analyses that are conducted after the preparation of initial cost estimates.

Showing FY 2017-18 Estimates from Multiple Points of View					
Total Costs	$DHS + $DMH + $DPH + $LASD + $Probation				
By Agency	$DHS	$DMH	$DPH	$LASD	Probation
***Per capita* Overall**	Total Cost / De-duplicated Total Clients				
***Per capita,* by Agency**	$DHS / DHS Patients				
	$DMH / DMH Patients				
	$SAPC/SAPC Patients				
	$LASD Jail + Booking /LASD Arrestees				
	$Adult Probation /Adult Probationers				
By Service Domain	Health: $DHS+$DMH+$DPH/SAPC				
	Mental Health: $DHS Psych + $DMH				
	Justice: $LASD + $Probation				
***Per Capita,* by Service Domain**	Health: $DHS+$DMH+$DPH /Unique Patients				

Varied Cost Perspectives

The 12-month Cost Estimates will be shown from several perspectives: (A) *Combined* expenditures across the five agencies; (B) *by agency*; (C) *Per capita* across the five agencies; (D) *Per capita*, by agency; (E*) combined within service domains*; (F) *per capita* within service domains. Expenditures can also be shown by demographic characteristics and other person-level factors, e.g. homelessness, justice involvement, specialty mental health service use, high-cost service use, etc.[1]

[1] The initial analysis prepared by DMH and CEO will not parse the Hollywood Estimate by the portions that are revenue-driven and those that are Net County Cost (NCC), which are expenditures charged against the County's General Fund.

	Mental Health: $DHS Psych + $DMH /unique Pts
	Justice: $LASD + $Probation / Unique Offenders

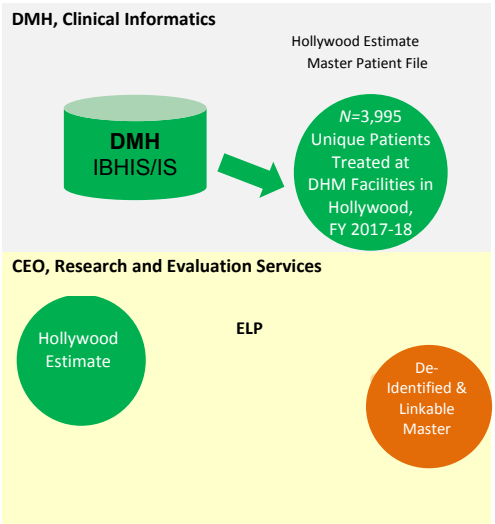
Los Angeles County's Integrated Data System

Observed Service use patterns among patients and clients receiving services through four of the agencies included in the Hollywood Estimate - DHS, DPH/SAPC, LASD and Probation will come the CEO's Enterprise Linkages Project (ELP), which is an Integrated Data System administered by RES since 2007.[2] ELP applies an algorithmic set of procedures to the data shared from agencies participating in the system's master agreement, which at once anonymize the sensitive elements in the administrative records and assign the associated clients a unique client-level identifier. These anonymous person-level identifiers can be linked and de-duplicated across agencies and *within* the same agency, which enables persons to be tracked in their encounters with agencies across service disciplines.

Eight of the nine agencies sharing data with the CEO are County Departments, the five noted above along with the Departments of Children and Family Services (DCFS), Public Social Services (DPSS), and Workforce Development, Aging and Community Services (WDACS). Additionally, the CEO has access to the Homeless Management Information System (HMIS) for the Greater Los Angeles Continuum of Care (GLA CoC). The HMIS data is shared with the CEO through a separate Data Use Agreement (DUA) with the Los Angeles Homeless Services Authority (LAHSA), which permits these records to be processed using the same algorithmic application that anonymizes records from the other eight County departments participating in the ELP data sharing arrangement and, in doing so, enables the County and HMIS data to be linked at the client level. The anonymization of these records from various systems allows the linkages across service disciplines to remain in conformity with privacy and confidentiality protocols and statutes.

DMH's Master Cohort File

DMH's Clinical Informatics Division has assembled a master Cohort file of all adults with records of receiving treatment and services through Departmental facilities located within the geographic boundaries of Hollywood during 2017-18. The patient cohort was derived based on claims data extracted from DMH's Integrated Behavioral Health System (IBHIS) and, to a lesser extent, its legacy IS system. The file



Within the County's Health Services delivery system *writ large* the overwhelming portion of direct servi ng is recoverable from the State. Within the justice domain, a considerably higher portion of Probation and LASD NCC. The distinction is important insofar as, everything else being equal, the desirability of minimizing NCC expe es and maximizing net revenues is essentially the County's fiscal orthodoxy. Drawing on the distinction meaningfully, however, will necessitate a deeper understanding of what the Trieste model's distinct funding mechanisms.

[2] From 2007 to 2010, the pilot version of ELP was known as the Adult Linkages Project (ALP). The name was changed to ELP in November 2010. At present, ELP is transitioning to an updated environment and set of internal applications. It is expected that the 'modernized' ELP will feature a significantly expanded array of data elements from all agencies participating in the ELP master agreement, of which DMH is one of the most critical.

contains basic Personally Identifiable Information (Name, DOB, SSN, Address, Basic Demographics, and the IBHS system identifier.

The cohort includes any DMH client who received at least 1 billable outpatient service at any of the designated service delivery programs within the Hollywood catchment area during fiscal year 2017-2018.

The following provider sites were identified for inclusion in defining the study cohort:

- LACDMH Directly Operated
  - 1909 HOLLYWOOD MENTAL HEALTH CENTER
  - 7739 HOLLYWOOD MHC WELLNESS CENTER
  - 7771 HOLLYWOOD MHC FSP PROGRAM
  - 7784 AMERICAN INDIAN COUNSELING CTR FSP
- LACDMH Contracted
  - 7106 LA GAY/LESBIAN COMM SVC CENTER
  - 7521 BHS HOLLYWOOD RECOVERY CENTER
  - 7805 STEP UP HOLLYWOOD
  - 7828 THE SABAN FREE CLINIC

A total of **3995**[3] distinct clients were identified for inclusion in the study population. The following distribution shows the included service programs through which cohort clients received FY1718 services. Within the cohort, 129 clients received services from more than one of the included service programs.

Service Program	Cohort Clients Seen
1909 HOLLYWOOD MENTAL HEALTH CENTER	3109
7739 HOLLYWOOD MHC WELLNESS CENTER	286
7771 HOLLYWOOD MHC FSP PROGRAM	141
7784 AMERICAN INDIAN COUNSELING CTR FSP	38
7106 LA GAY/LESBIAN COMM SVC CENTER	206
7521 BHS HOLLYWOOD RECOVERY CENTER	108
7805 STEP UP HOLLYWOOD	168

[3] For a number of reasons, including the need to draw data from both IBHIS and the IS and the erroneous creation of a new DMH Client ID by registration staff, a given "individual" may have received services that were submitted under 2 (or more) DMH Client ID's. To adjust for this, a statistical matching algorithm was used to link such ID's under a single common unique study ID. All analyses use this unique study ID to reconcile data associated to unique clients.

Mental Health Service Utilization and Cost Data

LACDMH Outpatient and Crisis Stabilization service information was based on FY1718 claims data processed by LACDMH as of 1/14/2019 and drew from both the legacy IS (Integrated System) and IBHIS (the Integrated Behavioral Health Information System). LACDMH inpatient and other 24-Hour Residential utilization and cost data was derived, depending on the given facility, from IBHIS claims data, from IS episode data, or from IBHIS episode data. Because much of the inpatient and residential care is not reimbursed through claims transactions per se (i.e., rather are billed via invoice or are authorized by LACDMH then paid directly to the facility by the State) cost associated to episodic data was derived by determining the length of stay and multiplying by the daily rate for each facility[4].

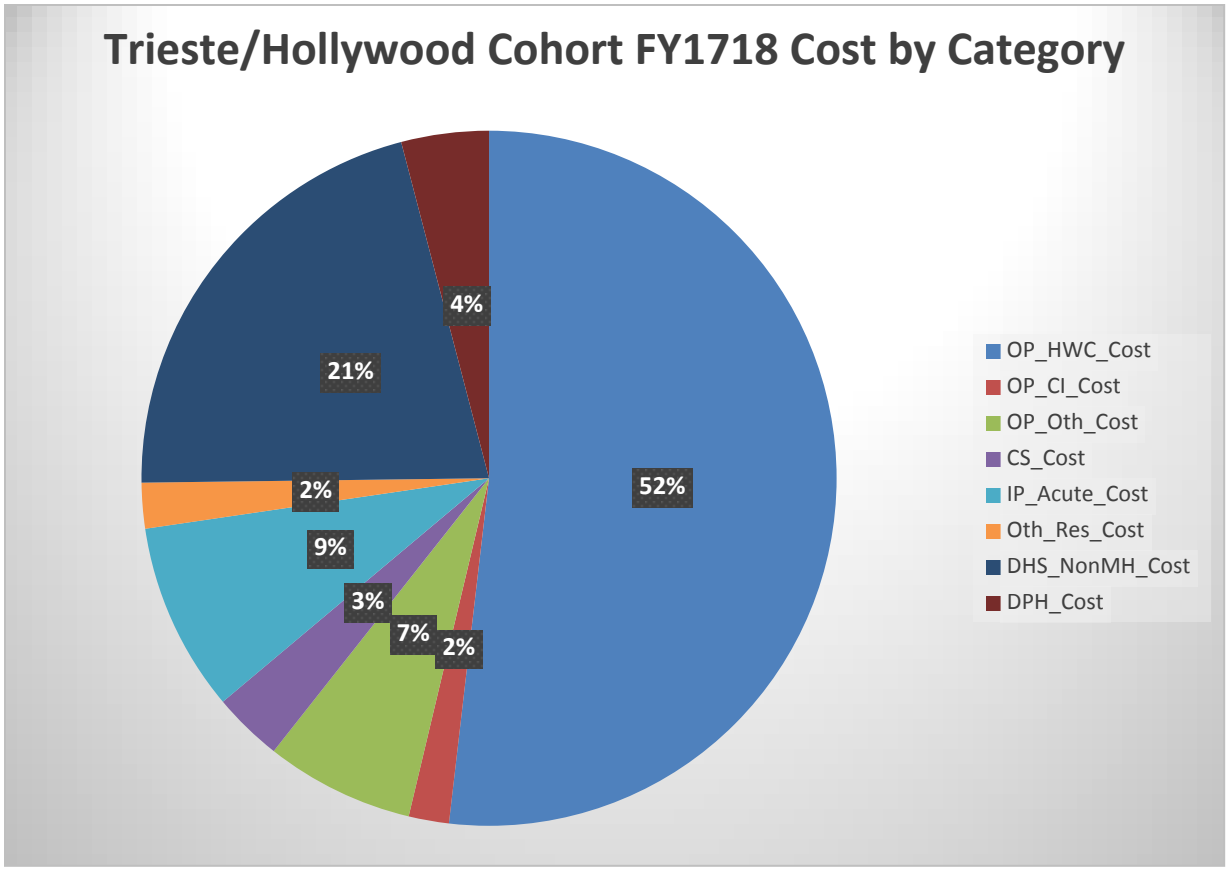
Other Health-Related Service Utilization and Cost Data

In addition, the Office of Clinical Informatics securely transferred a file identifying the cohort to the CEO/CIO Service Integration Branch so that it could be linked to FY1718 cost data from the Department of Health Services (DHS) and the Department of Public Health (DPH). Data from DHS excluded those costs associated to their Psychiatric Emergency Services (PES) and the psychiatric inpatient units to avoid double counting costs already captured in the DMH data.

Cost Categories

Category	Description
OP_HWC_Cost	Outpatient services received through any of the "included" Hollywood programs
OP_CI_Cost	Outpatient Crisis Intervention services received through a non-included MH program (the majority of these were through DMH PMRT or LET programs)
OP_Oth_Cost	All other outpatient services received through a non-included MH program
CS_Cost	Crisis Stabilization through a Psychiatric ER or Psychiatric UCC
IP_Acute_Cost	Acute psychiatric Inpatient services
Oth_Res_Cost	All other residential MH services
DHS_NonMH_Cost	DHS service costs excluding DHS psychiatric services
DPH_Cost	DPHh Substance Abuse Prevention and Control (SAPC) services

[4] When episodes overlapped the beginning or end of the study period an adjusted LOS was derived so as not to count costs outside of the study period. Similarly, a facility-type Average Length of Stay (ALOS) was used when it appeared that there was a spurious omission of an inpatient discharge date.



Cohort Costs, by Service and, by Service Types and Categories						
Category	Number of Clients with Cost	Total FY1718 Cost	Minimum	Max	Mean among those with these services	Mean of cost across study cohort
OP_HWC_Cost	3995	$14,127,571.11	$2.47	$120,893.73	$3,536.31	$3,536.31
OP_CI_Cost	214	$547,456.16	$133.76	$29,218.08	$2,558.21	$137.04
OP_Oth_Cost	422	$1,848,191.14	$2.88	$67,292.06	$4,379.60	$462.63
CS_Cost	493	$885,252.41	$120.00	$25,776.68	$1,795.64	$221.59
IP_Acute_Cost	228	$2,396,447.31	$660.00	$120,120.00	$10,510.73	$599.86
Oth_Res_Cost	33	$578,208.79	$354.01	$98,441.82	$17,521.48	$144.73
DHS_NonMH_Cost	448	$5,758,260.06	$491.64	$562,951.26	$12,853.26	$1,441.37
DPH_Cost	143	$1,109,094.46	$30.00	$57,591.97	$7,755.91	$277.62
TOTAL	**3995**	**$27,250,481.44**	**$2.47**	**$635,624.01**	**$6,821.15**	**$6,821.15**

Establishment of a Comparative Baseline

The expenditures shown in the table above established the beginnings of a comparative baseline against which to gauge a Trieste pilot group both overall and by cost categories and service modalities. In the aggregate, the cohort's combined cost across the three agencies shown was $27.3 Million, which averages to slightly more than $6,821 per person. To a certain extent, artificial understatement of the costs is eliminated as a confounding factor since the cohort was selected based on encounters at DMH facilities,

which means the cohort does not include any individual who incurred no expenses, though the minimum cost of $2.47 suggests there may be some merit in filtering out persons who incur costs falling below a specified threshold value.

Given the availability to DMH and RES of de-identified data in other service disciplines (justice, social services, child protection, workforce development, homeless services) additional cost components could be added to the comparative analysis, thereby offering a more exhaustive sense of the degree to which the pilot successfully offsets wasteful expenditures while promoting engagement with more cost efficient services and forms of treatment shown in evidence-based research to be associated with better outcomes.

AGENDA ITEM 4

Action

May 27, 2021 Commission Meeting

Santa Clara County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Santa Clara County's request to fund the following new Innovative project:

1. **Community Mobile Response Program**

Santa Clara County is requesting up to $27,949,227 of Innovation spending authority to develop and implement a crisis response system, utilizing a community-based approach, to provide immediate crisis services for those in need. **This program will utilize the community model Crisis Assistance Helping Out in the Streets (CAHOOTS) with modifications to respond to mental health crises using peers, community residents, mental health workers, and emergency medical support to reduce the involvement of law enforcement in mental health crisis emergencies.**

The modifications to the CAHOOTS model will include:

- Opportunity for Call Team to de-escalate over the phone,
- Law enforcement will not be involved unless necessary,
- Onsite Field Team will have the option to dispatch the County's Psychiatric Emergency Response Team or the Mobile Crisis Response Team (contains Law Enforcement personnel),
- Any law enforcement personnel dispatched will receive training in Crisis Intervention.

The County has identified these problems which led to the development of this project:

- Distressing encounters between individuals in mental health crisis and law enforcement.
- Communities with historical trauma due to negative interactions with government authority are fearful to seek assistance for fear of being unnecessarily hospitalized or incarcerated.
- County's current mental health crisis programs require inclusion of law enforcement.
- Individuals not deemed 5150 may not receive linkages or supports post-crisis that can lead to repeated calls for emergency services.
- Ambulances and law enforcement vehicles are currently utilized to transport individuals placed on a 5150 hold, leading to trauma and stigma.
- People of color in the community have expressed reluctance to seek mental health assistance when needed due to stigma attached to behavioral health.

This project aims to address behavioral health crises by creating a response system that does not require the response of law enforcement unless deemed necessary, thereby reducing fear from possible traumatic encounters and encourages the support of peers, volunteers, mental health advocates, and emergency personnel.

The elements of this project include the following:

Service Areas

As a result of stakeholder input, the County selected three areas to implement this Community Mobile Response Program:

1. San Jose
2. Gilroy
3. North County

These areas have a concentration of people of color and refugees who have a history of being underserved and over-policed. The Gilroy area was chosen by the Community due to lack of available services in the area and the high rate of social vulnerability, according to Centers for Disease Control. Social vulnerability refers to potentially negative effects on communities caused by external stresses on human health and by reducing social vulnerability, human suffering and economic loss will also decrease (see reference section for CDC Index info).

Call Center Teams (*see page 15 of project)*

- The Call Center will be staffed 24 hours per day, 7 days per week, managed by a Community Based Organization. *Staff with lived experience have been recognized by the Community as an important component of this team, and may include peer specialists, families of peers, paraprofessionals, and volunteers.*
- The Community also expressed a need for an easy-to-remember three-digit number, separate from the traditional 911 or 311 number. This designated number will be determined by the Community during implementation of this project.
    - Commission staff met with the County to discuss new Assembly Bill 988 that is currently going through the legislative process. This Bill will establish a National Crisis Hotline Number (988). It is uncertain if this Bill will be enacted into law; however, the County stated stakeholders in their County did not want to pause on the momentum of this project due to the uncertainly of Bill 988 passing. Additionally, Santa Clara stakeholders specifically want a number that is for the community only, not inclusive of law enforcement.

Onsite Field Teams (*see page 16-17 of project)*

Each location above will have their own Community Mobile Response (CMR) Team, staffed with the following personnel:

- 1.0 FTE Community Collaborator
- 1.5 FTE Licensed Program Manager
    - Onsite Field Teams will include the following:
        - 4.5 FTE Emergency Medical Technicians
        - 4.5 FTE Crisis Intervention Workers
        - 4.5 FTE Peer Outreach Specialists
- Each Field Team will have a total of 16 FTEs

Workflow for Call Centers and Onsite Field Teams (*see page 16-17 of project)*
The Call Center Team will be trained on how to de-escalate situations over the phone, an important component for stakeholders.

In the event the crisis is de-escalated over the phone, the Call Center Team will follow up with the individual within 24-72 hours. If further assistance is needed, or if de-escalation is not sufficient, the Call Center Team will dispatch the CMR Onsite Field Team to the individual in need. If the CMR Onsite is dispatched, they will be responsible to provide follow-up to the individual in need within 24-72 hours with appropriate linkages and referrals for support and/or services.

Vehicles
Three utility vans will be purchased for the Field Team. Community stakeholders voiced the importance of a calming environment that does not resemble law enforcement or government authority. The interior of the vehicles will be equipped with the following:

- A safe, calming, therapeutic environment,
- A bench or bed for individuals to relax,
- Calming items such as fidget spinners, stress balls, food, and water,
- Basic medical equipment,
- Capability to transport individual plus a family member, as needed.

The exterior of the vehicles will have the following:

- Appearance that will minimize anxiety or stress,
- Will not look like an official government vehicle,
- Neutral exterior color with a discreet logo to minimize stigma.

Design Logo / Vendor
To promote community collaboration and partnership for this project, the County, the Stakeholder Leadership Committee, and the Behavioral Health Contractors Association, will hold a contest for a local community artist to assist in designing a logo for the CMR Project. Designs from this contest will be shared with focus groups and stakeholders who will vote on the top design, awarding the local artist $5,000 as a prize. The artist and design firm will work to develop the winning design logo and modify/adjust so that the logo can be displayed on the van's exterior, uniforms, and any outreach items. ***All outreach and engagement items will be translated into the County's five threshold languages: Spanish, Vietnamese, Chinese, Tagalog, and Farsi.***

Outreach Events
To increase awareness and stigma, the program will attend various events within the Community in Gilroy and San Jose. The Onsite Field Teams will allow community members to tour the inside of the vehicles and will be able to meet with the teams providing these community response services. As a result of the transitional age youth voice, the program will open a social media account to showcase the vehicles and provide an overall view of what they can expect should they ever need to contact the program for a crisis intervention.

Program Name
Although this project is currently called Community Mobile Response, the Community was vocal about the desire for this program to have a positive therapeutic presence while in the Community, and as a result, did not want the word Crisis as part of project.

Members of the Stakeholder Leadership Committee and the Behavioral Health Contractors Association will continue to work with the Community in the coming weeks to select a more appropriate name.

The County held their 30-day public comment period from October 17, 2020 through November 16, 2020; however, the County decided to extend the public comment period to November 24, 2020 so that the Community had additional time to provide feedback based on additional revisions to this project based on the SLC meetings held between October and November.

As a result of additional feedback and the refining of the moving components of this project, the County decided to hold an additional 30-day public comment period from February 12, 2021 through March 14, 2021. A total of 15 comments were received and were submitted by the County as an Appendix. The County held a public meeting on March 15 and March 23, 2021 to discuss all comments received and the additional components within the plan.

After the robust feedback from the Community over several months, the County held their Mental Health Board Meeting on April 12, 2021, followed by Board of Supervisor approval on April 20, 2021.

Commission staff originally shared this project with its six stakeholder contractors and the listserv on three separate dates: November 24, 2020 while the County was in their 30-day public comment period and comments were to be directed to the County; again, on February 16, 2021 during the County's subsequent 30-day public comment period and the final version of this project was shared on April 22, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees on April 22, 2021.

One comment was received in response to Commission sharing this plan with stakeholder contractors and the listserv:

- *I was involved in the very early planning stages and know that this is a very needed program in Santa Clara County. It is unfortunate that all of these projects take so long to get implemented due to the work intensive planning, presentations, and approval. I would also state that I was involved with the start of CIT and PERT in San Jose and still believe that we need this new program. I have no problem with my name being included. (Sharon Roth)*

Enclosures (3): (1) Biography for Santa Clara County's Innovation Presenter; (2) Staff Analysis: Community Mobile Response Program; (3) Letters of Support

Handout (1): PowerPoint Presentation: Community Mobile Response Program

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

Community Mobile Response Program:

https://mhsoac.ca.gov/sites/default/files/SantaClara_INN_Plan_CMR.pdf

Proposed Motion: The Commission approves Santa Clara County's Innovation plan, as follows:

Name: Community Mobile Response Program

Amount: Up to $27,949,227 in MHSA Innovation funds

Project Length: Four years and 6 months (4.5) years

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Jeanne Moral
Program Manager III
Systems Initiatives, Planning & Communication

Jeanne Moral, Program Manager III, oversees the Systems Initiatives, Communication and Planning Division for the County of Santa Clara Behavioral Health Services Department (BHSD). In her role, Ms. Moral oversees the BHSD MHSA Team responsible for the community planning process of the Santa Clara County's Annual Update and Three-Year Planning Process regarding the five components of the MHSA plan, including the Innovation component. Ms. Moral also manages system-wide initiatives and projects for BHSD and oversees the Behavioral Health Board Liaison Team that supports the Santa Clara County's Behavioral Health Board.

STAFF ANALYSIS – Santa Clara County

Innovation (INN) Project Name:	**Community Mobile Response (CMR) Program**
Total INN Funding Requested:	**$27,949,227**
Duration of INN Project:	**4.5 Years**
MHSOAC consideration of INN Project:	**May 27, 2021**

Review History:

Approved by the County Board of Supervisors:	April 20, 2021
Mental Health Board Hearing:	April 12, 2021
Public Comment Period:	February 12, 2021 – March 14, 2021 & October 17, 2020 - November 24, 2020
County submitted INN Project:	April 13, 2021
Date Project Shared with Stakeholders:	November 24, 2020; February 16, 2021; and April 22, 2021

Project Introduction:

Santa Clara County is requesting up to $27,949,227 of Innovation spending authority to develop and implement a crisis response system, utilizing a community-based approach, to provide immediate crisis services for those in need. This program will utilize the community model Crisis Assistance Helping Out in the Streets (CAHOOTS) with modifications to respond to mental health crises using peers, community residents, mental health workers, and emergency medical support to reduce the involvement of law enforcement in mental health crisis emergencies.

What is the Problem?

Over the past year with racial injustice and systemic racism at the forefront in our society, the Community in Santa Clara has expressed to the County the need to develop a response system for those experiencing a mental health crisis without the involvement of law enforcement. The County has identified these problems which led to the development of this project:

- Distressing encounters between individuals in mental health crisis and law enforcement
- Communities with historical trauma due to negative interactions with government authority are fearful to seek assistance for fear of being unnecessarily hospitalized or incarcerated

- County's current mental health crisis programs require inclusion of law enforcement
- Individuals not deemed 5150 may not receive linkages or supports post-crisis that can lead to repeated calls for emergency services
- Ambulances and law enforcement vehicles are currently utilized to transport individuals placed on a 5150 hold, leading to trauma and stigma
- People of color in the community have expressed reluctance to seek mental health assistance when needed due to stigma attached to behavioral health

This project aims to address behavioral health crises by creating a response system that does not require the response of law enforcement unless deemed necessary, thereby reducing fear from possible traumatic encounters and encourages the support of peers, volunteers, mental health advocates, and emergency personnel.

How this Innovation project addresses this problem:

This original idea for this project was drafted by the Behavioral Health Contractors Association of Santa Clara (BHCA), an organization comprised of over 30 non-profit community-based organizations. The idea was based off a model from Eugene, Oregon known as CAHOOTS (Crisis Assistance Helping Out in the Streets). BHCA described this model in a presentation to the Board of Supervisors, and also came forward to the MHSA Stakeholder Leadership Committee (SLC), as a potential innovation project, which then drew support from the Community.

The County began to look at the CAHOOTS model and decided to modify parts of the model and apply it to the specific needs in Santa Clara County (*see page 17 and 19 of project*).

The modifications of the CAHOOTS model will include:

- Opportunity for Call Team to de-escalate over the phone
- Law enforcement will not be involved unless necessary
- Onsite Field Team will have the option to dispatch the County's Psychiatric Emergency Response Team or the Mobile Crisis Response Team (contains Law Enforcement personnel)
- Any law enforcement personnel dispatched will receive training in Crisis Intervention

The elements of this project include the following:

Service Areas

As a result of stakeholder input, the County selected three areas to implement this Community Mobile Response Program:

1. San Jose
2. Gilroy
3. North County

These areas have a concentration of people of color and refugees who have a history of being underserved and over-policed. The Gilroy area was chosen by the Community due to lack of available services in the area and the high rate of social vulnerability, according to Centers for Disease Control. Social vulnerability refers to potentially negative effects on communities caused by external stresses on human health and by reducing social vulnerability, human suffering and economic loss will also decrease (see reference section for CDC Index info).

Call Center Teams *(see page 15 of project)*

- The Call Center will be staffed 24 hours per day, 7 days per week, managed by a Community Based Organization. *Staff with lived experience have been recognized by the Community as an important component of this team, and may include peer specialists, families of peers, paraprofessionals and volunteers.*
- The Community also expressed a need for an easy-to-remember three-digit number, separate from the traditional 911 or 311 number. This designated number will be determined by the Community during implementation of this project.
    - Commission staff met with the County to discuss new Assembly Bill 988 that is currently going through the legislative process. This Bill will establish a National Crisis Hotline Number (988). It is uncertain if this Bill will be enacted into law; however, the County stated stakeholders in their County did not want to pause on the momentum of this project due to the uncertainly of Bill 988 passing. Additionally, Santa Clara stakeholders specifically want a number that is for the community only, not inclusive of law enforcement.

Call Center Teams will:

- Be trained on how to triage calls
- Pick up and respond to calls in a timely manner
- Receive mental health training, including cultural responsiveness

Onsite Field Teams *(see page 16-17 of project)*

Three separate Field Teams will be created for the three sites above Each location will have their own Community Mobile Response (CMR) Team. Each of the three teams will be staffed with the following personnel:

- 1.0 FTE Community Collaborator
- 1.5 FTE Licensed Program Manager
    - Onsite Field Teams will include the following
        - 4.5 FTE Emergency Medical Technicians
        - 4.5 FTE Crisis Intervention Workers
        - 4.5 FTE Peer Outreach Specialists
- ➢ Each Field Team will have a total of 16 FTEs

Workflow for Call Centers and Onsite Field Teams (*see page 16-17 of project)*

The Call Center Team will be trained on how to de-escalate situations over the phone, an important component for stakeholders.

In the event the crisis is de-escalated over the phone, the Call Center Team will follow up with the individual within 24-72 hours. In the event that further assistance is needed or de-escalation is not sufficient, the Call Center Team will dispatch the CMR Onsite Field Team to the individual in need. If the CMR Onsite is dispatched, they will be responsible to provide follow-up to the individual in need within 24-72 hours with appropriate linkages and referrals for support and/or services.

Vehicles

Three utility vans will be purchased for the Field Team. Community stakeholders voiced the importance of a calming environment that does not resemble law enforcement or government authority. The interior of the vehicles will be equipped with the following:

- A safe, calming, therapeutic environment
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The exterior of the vehicles will have the following:

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Design Logo / Vendor

To promote community collaboration and partnership for this project, the County, the Stakeholder Leadership Committee, and the Behavioral Health Contractors Association, will hold a contest for a local community artist to assist in designing a logo for the CMR Project. Designs from this contest will be shared with focus groups and stakeholders who will vote on the top design, awarding the local artist $5,000 as a prize. The artist and design firm will work to develop the winning design logo and modify/adjust so that the logo can be displayed on the van's exterior, uniforms, and any outreach items. ***All outreach and engagement items will be translated into the County's five threshold languages: Spanish, Vietnamese, Chinese, Tagalog, and Farsi.***

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Program Name

Although this project is currently called Community Mobile Response, the Community was vocal about the desire for this program to have a positive therapeutic presence while in the Community, and as a result, did not want the word Crisis as part of project. Members of the Stakeholder Leadership Committee and the Behavioral Health

Contractors Association will continue to work with the Community in the coming weeks to select a more appropriate name.

Community Planning Process: (*see pages 29-35 of the project plan*)

Local Level

Santa Clara County receives guidance from a MHSA Stakeholder Leadership Committee (SLC) consisting of representatives of various stakeholder groups, including consumers, family members and underserved cultural communities. The SLC provides input and advises the County in its MHSA planning and implementation activities, ensuring MHSA General Standards have been met.

The County held their 30-day public comment period from October 17, 2020 through November 16, 2020; however, the County decided to extend the public comment period to November 24, 2020 so that the Community had additional time to provide feedback based on additional revisions to this project based on the SLC meetings held between October and November.

The community expressed a desire to continue the planning process to allow more consumers and stakeholder to provide input on this project; additionally, the community expressed that Santa Clara Behavioral Health Services Department (BHSD) work with the Behavioral Health Contractors Association (BHCA), an organization comprised of more than 30 non-profit community-based organizations. As a result, BHSD and BHCA worked collaboratively and in partnership and held 13 planning sessions to involve more of the community with specific input from diverse groups (see page 30). As a result of additional feedback and the refining of the moving components of this project, the County decided to hold an additional 30-day public comment period from February 12, 2021 through March 14, 2021. A total of 15 comments were received and were submitted by the County as an Appendix. The County held a public meeting on March 15 and March 23, 2021 to discuss all comments received and the additional components within the plan.

After the robust feedback from the Community over several months, the County held their Mental Health Board Meeting on April 12, 2021, followed by Board of Supervisor approval on April 20, 2021.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on three separate dates: November 24, 2020 while the County was in their 30-day public comment period and comments were to be directed to the County; again on February 16, 2021 during the County's subsequent 30-day public comment period and the final version of this project was shared on April 22, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees on April 22, 2021.

One comment was received in response to Commission sharing this plan with stakeholder contractors and the listserv:

- *I was involved in the very early planning stages and know that this is a very needed program in Santa Clara County. It is unfortunate that all of these projects take so long to get implemented due to the work intensive planning, presentations and approval. I would also state that I was involved with the start of CIT and PERT in San Jose and still believe that we need this new program. I have no problem with my name being included. (Sharon Roth)*

Learning Objectives and Evaluation: (*see pages 26-29 of the project plan*)

The County hopes to provide crisis response services via a Call Center staffed by peers and volunteers through three Field Teams in San Jose, Gilroy, and the Northern part of the County, without the use of law enforcement unless absolutely necessary. This program will operate 24/7, 365 days per year and will aim to serve as many individuals over the age of 18 as possible. The County proposes to serve a minimum of 5,000 individuals on an annual basis, given the propensity that more calls will be received when there is less likelihood of law enforcement involvement.

The learning goals are qualitative and quantitative in nature and focus on how the lives of individuals will be impacted, and include:

1. By using de-escalation techniques, will this new program minimize the need for clients to be transported to the hospital or jail and instead when appropriate transport to other destinations such as housing shelters, sobering center, and other CBO programs?

2. Will this new program encourage community members to seek help when needed?

3. Will a collaborative approach involving community collaborators and other service providers (partner agencies, EMS, BHSD County Programs) help with increased use of the program?

4. Can the program lower the utilization rate of emergency services for behavioral health needs?

5. Can the stigma associated with seeking mental health assistance be lowered if services are provided in a safe, inviting, culturally informed, non-judgmental way?

6. Can the program lower the number of repeat callers for behavioral health crisis assistance by providing linkage and follow-up services to individuals post crisis?

An independent evaluator will be contracted to conduct a complete process and outcome evaluation of the project with an emphasis on outcomes and the number and frequency of the targeted populations' access to crisis services, satisfaction with contact between

individuals and program staff, ultimately leading to whether this project will be sustained, or parts thereof.

The following are a few of the identified outcomes relative to each of the learning goals (see page 28 of project plan for complete list):

- Decrease in the number of deaths due to law enforcement involvement in comparison with crises serviced by the Community staffed in this project
- Decrease in the number of individuals being hospitalized or incarcerated due to involvement with members of the Community staffed in this project
- Decrease in the overall negative impact and discrimination in relation to law enforcement involvement with communities of color

The Budget *(see pgs 39-49 of project plan)*

54-Month Budget	Year-1 (12 months)	Year-2 (12 months)	Year-3 (12 months)	Year-4 (12 months)	Year-5 (6 months)	**Total**
Personnel	$ 180,467	$ 180,467	$ 180,467	$ 180,467	$ 90,234	$ 812,102
Direct Costs	$ 2,618,987	$ 5,237,975	$ 5,237,975	$ 5,237,975	$ 2,618,988	$ 20,951,900
Indirect Costs	$ 830,791	$ 1,661,582	$ 1,661,582	$ 1,661,582	$ 830,791	$ 6,646,328
Non-recurring costs	$ 351,000					$ 351,000
Other Expenditures	$ -	$ -	$ -	$ -	$ -	$ -
						$ -
Total Project Expenditures	**$ 3,981,245.00**	**$ 7,080,024.00**	**$ 7,080,024.00**	**$ 7,080,024.00**	**$ 3,540,013.00**	**$ 28,761,330.00**

Funding Source	Year-1 (12 months)	Year-2 (12 months)	Year-3 (12 months)	Year-4 (12 months)	Year-5 (6 months)	**Total**
Innovation Funds	$ 3,800,778	$ 6,899,557	$ 6,899,557	$ 6,899,557	$ 3,449,778	$ 27,949,227
Medi-Cal FFP						$ -
1991 Realignment						$ -
Behavioral Health Subaccount						$ -
Any other funding						$ -
Total	**$ 3,800,778.00**	**$ 6,899,557.00**	**$ 6,899,557.00**	**$ 6,899,557.00**	**$ 3,449,778.00**	**$ 27,949,227.00**

The County is requesting authorization to spend up to $27,949,227 in MHSA Innovation funding for this project over a period of 4.5 years.;

The budget includes:

- Direct costs total $20,951,900 (72.8% of total project amount) to cover the following costs:
    - Evaluation contract ($200,000); implementation of 3 Digit Call Center number ($3,600); and salaries for Community Based Service Contracts employees who will staff the Call Center and Field Teams ($20,748,300)

- Indirect costs total $6,646,328 (23% of total project amount) and will cover partial expenditures associated with general administrative overhead, operating expenditures and personnel costs
- One-time costs in the amount of $351,000 (1.2% of total project amount) will cover purchases and modifications to 3 utility vans, and monetary awards for the winner of the Community Design Contest for creation of the logo and for the Vendor to work with transforming the designed logo for placement onto vehicles, pamphlets, and uniforms
- The County has utilized **Non-MHSA funding** for the hiring of a Program Manager III position in the amount of $812,102 – covered by County General Fund and not included as part of the INN funding request

The County will be using funds subject to reversion as of June 30, 2021 and have submitted three (including this one) innovation projects for approval that total $30,692,367. One of which was approved on February 25, 2021 in the amount of $1,753,140.

The County will rely on the evaluation to determine the sustainability of this project once ended and will include analyzing which components of this project will continue and what funding streams can be utilized.

On April 20, 2021, the Santa Clara County Board of Supervisors approved the project and authorized Santa Clara Behavioral Health Services Department (BHSD) to submit the INN project and budget request for the project to the MHSOAC. Upon approval of The Commission of the project, BHSD will submit a legislative file report to the Santa Clara County Board of Supervisors to provide them an update regarding The Commission's approval of this project and recognize the formal approval of the project including the funding approved by The Commission. If BHSD obtains MHSOAC approval, the plan is to submit the legislative file report to the Santa Clara County Board of Supervisors on June 8, 2021, to recognize state approval of the project and its funding.

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

Comments:
During the review of this plan, Commission staff met with the County to discuss whether Triage funds could be utilized for this project. The county indicated they did apply for a School Collaboration Triage Grant but was not awarded.

References:

https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

From: Reedy, Grace@MHSOAC
To: Reedy, Grace@MHSOAC
Subject: FW: Community Mobile Response
Date: Thursday, May 06, 2021 10:27:37 AM

-----Original Message-----
From: Sharon Roth <[redacted]>
Sent: Wednesday, November 25, 2020 2:04 PM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Subject: Community Mobile Response

I was involved in the very early planning stages, and know that this is a very needed program in Santa Clara County. It is unfortunate that all of these projects take so long to get implemented due to the work intensive planning, presentations and approval. I would also state that I was involved with the start of CIT and PERT in San Jose and still believe that we need this new program. I have no problem with my name being included.

Sharon

Sharon Roth

Sent from my iPad

May 10, 2021

Mental Health Services Oversight & Accountability Commission

1325 J Street, Suite 1700

Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of the NAMI Santa Clara County, I write in support of the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021. As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police and emergency departments. For communities that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, and even result in a deadly experience. This new, innovative program will utilize a community-based approach in addressing behavioral health crisis calls as an alternative to law enforcement response.

We support the CMR programmatic elements: an onsite field team comprised of an emergency medical technician, crisis intervention worker, and peer outreach specialist, prevention-focused programming, family involvement component, accessibility of the program through a trusted phone line not associated with law enforcement, and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and North County.

The mission and values of NAMI Santa Clara County are to help people with a lived experience of mental illness and families by providing support, education and advocacy; to promote research; to reduce stigma and discrimination in the community; and to improve services by working with mental health professionals and families.

The CMR program was selected by MHSA stakeholders and supported by community members as an MHSA Innovation project based on its direct impact on marginalized communities, highly impacted by current issues of race equity and social justice in accessing behavioral health crisis services.

I urge you, especially during this time, to approve this project that will bring much-needed resources to Santa Clara County.

Sincerely,

Rovina Nimbalkar

Rovina Nimbalkar
Executive Director
NAMI- Santa Clara County

1150 South Bascom Ave., Ste. 24 San José, CA 95128-3509 Phone: 1.408.453.0400 • Fax: 1.408.453.2100
E-mail: info@namisantaclara.org • Website: www.namisantaclara.org

Bill Wilson Center
Building Connections for Youth and Families

3490 The Alameda
Santa Clara, CA 95050
(408) 243-0222 *tel*
(408) 246-5752 *fax*
www.billwilsoncenter.org

May 11, 2021

Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of Bill Wilson Center, I support the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021. As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police and emergency departments in a negative manner. For communities that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, and even result in a deadly experience. As someone who initiated and pushed forward the idea that an alternative to a police response for non-life threatening crisis calls from under-represented populations in our County must be possible, I know this innovative model of response will utilize a community-based approach to address behavioral health crisis calls as an alternative to a law enforcement response.

Bill Wilson Center supports all of the CMR programmatic elements: an onsite field team comprised of an emergency medical technician, crisis intervention worker and peer outreach specialist; prevention-focused programming; family involvement component; accessibility of the program through a trusted phone line not associated with law enforcement; and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and North County.

As the CEO of a non-profit helping homeless youth and families, I see every day how underserved and under-represented populations in our County are negatively impacted by their experiences with law enforcement. I am proud to say I was instrumental in ensuring the CMR program was developed with a tremendous amount of community input. Indeed, community input was critical to the project truly being community driven, culturally responsive, and in line with the unique needs of Santa Clara County.

The CMR program was selected by MHSA stakeholders and supported by community members (including Bill Wilson Center and a group of 17 other CBOs who came together to develop the project framework) as an MHSA Innovation project based on its direct impact on under-represented communities highly impacted by current issues of race equity and social justice.

I urge you, especially now, during this time when the use of police force must be re-evaluated, to approve this project that will bring much-needed help to under-represented residents of Santa Clara County.

Sincerely,

Sparky Harlan
Chief Executive Officer

Behavioral Health Contractors' Association
of Santa Clara County
1530 The Alameda, Suite 301
San Jose, CA 95126
Phone: (408) 579-6033 ▪ elisak@bhcascc.org

May 7, 2021

Commissioners
The Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioners,

The Santa Clara County Behavioral Health Contractors' Association (BHCA) is pleased to submit this letter in support of Santa Clara County's proposal for the Mental Health Services Act (MHSA) Innovation (INN) #15 Project: Community Mobile Response (CMR) Program.

BHCA is a Santa Clara County-wide network of community-based, non-profit organizations providing essential mental health and substance use prevention, treatment, recovery, and supportive transitional housing services to children, adolescents, and adults, under contract with Santa Clara County's Behavioral Health Services Department.

As a result of the brutal murders of George Floyd, Breonna Taylor, Ahmaud Arberty and countless other Black and people of color, the County embarked on a review of law enforcement responses to crisis calls in cities throughout the US and engaged stakeholders in dialogue to identify how best to serve the mental health and crisis needs of residents that would not require a law enforcement response.

This process led to the identification of practices that involve a holistic approach to crisis calls that include: family involvement, quick access via identified vehicles, use of a trusted phoneline, utilization of trauma-informed approaches, and partnering with other community resources to respond to crisis calls. The model offers a unique approach to calls that utilizes medical, behavioral, and peer support, 24/7 365 days, focusing in on three areas with the highest need based on crisis response data. The intent of the Community Response Program is to respond to non-criminal calls, such as behavioral health issues, substance use, truancy,

Member Agencies

AACI
Abode Services
Advent Group Ministries
Alum Rock Counseling Center
Bill Wilson Center
Caminar
Catholic Charities
Children's Health Council
Community Solutions
Fred Finch Youth Center
Gardner Family Care Corporation
HealthRight 360
HealthTrust
Home First
Hope Services
Horizon Services
Indian Health Center
Kidango
LifeMoves
Mekong Community Center
Mental Health Advocacy Project
Mental Health Systems
Momentum for Mental Health
National Alliance on Mental Illness
Parisi House on the Hill
PATH
Pathway Society
Peninsula Healthcare Connection
Rebekah Children's Services
Seneca Kinship Center
Ujima Adult & Family Services
Uplift Family Services

homelessness, family conflict, and other community issues. Additionally, the Program offers a community response in line with equity, and justice by having trusted, trained and diverse community mental health workers respond to calls that require trauma informed interventions which helps to de-escalate situations.

The Association fully supports the innovative model, and its members believe it will lead to better outcomes and will be adopted by other communities throughout the state.

Sincerely,

Elisa Koff-Ginsborg
Executive Director

California Alliance
Empowering lives. Enriching futures.

May 10, 2021

Honorable Commissioners
The Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Honorable Commissioners,

The California Alliance of Child and Family Services (California Alliance) is proud to support Santa Clara County's proposal for the Mental Health Services Act (MHSA) Innovation (INN) #15 Project: Community Mobile Response (CMR) Program. The California Alliance represents 150 nationally accredited non-profit community-based organizations serving children, youth, and families in public human services systems.

The CMR program will not only have an important impact on Santa Clara County, but also tests a new model that can potentially serve as a resource for many other communities across the State. Santa Clara County's Innovation project proposes to create a different kind of response when an adult is experiencing a mental health crisis – one that is trauma informed and focused on the needs of the individual.

The model offers a unique approach to calls that utilizes medical, behavioral, and peer support, focusing in on three areas in Santa Clara County with the highest need based on crisis response data. The intent of the program is to respond to non-criminal calls, such as behavioral health issues, substance use, truancy, homelessness, family conflict, and other community issues. Additionally, the program offers a community response in line with equity and justice by having trusted, trained, and diverse community mental health workers respond to calls that require trauma informed interventions.

We believe this proposal also ties in with the state and national work happening to implement 988 across the U.S.

We fully support this innovation proposal and believe that it that will lead to better outcomes in Santa Clara County. If you have any questions, please contact Adrienne Shilton at ashilton@cacfs.org or (916) 397-9405.

Sincerely,

Adrienne Shilton

Adrienne Shilton, Senior Policy Advocate
California Alliance of Child and Family Services

Uplift Family Services
Formerly EMQ FamiliesFirst

May 10, 2021

Commissioners
The Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioners,

I write this letter of support for **Santa Clara County's Mental Health Services Act (MHSA) Innovation (INN) #15 Project: Community Mobile Response (CMR) Program**. The program offers critical alternate services and a unique combination of medical, behavioral, and peer support. The Community Mobile Response Program will respond to a variety of non-criminal calls, including mental health, substance use, truancy, homelessness, family conflict, and other needs. By utilizing these staff teams in the communities most in need, it will enhance non-law enforcement quick-response, best matching the issue at hand with staff trained in mental health and connected to the community and follow-up resources. Community leaders have voiced support for a non law-enforcement approach to these types of calls, which this program addresses. It has pulled the best elements from models used in cities throughout the country with successful outcomes, including 24/7 services, an additional component of community engagement, a centralized number, utilization of vans, and a comprehensive approach with peers, mental health, medical support.

As an active member on committee that developed this model, I have experienced the strong amount of research, intensive community stakeholder feedback process, and dialogue that has led to this model. Our agency strongly supports this model and I respectfully request the MHSOAC approve this project.

Respectfully Submitted,

Regional Executive Director

Headquarters/Bay Region
251 Llewellyn Avenue
Campbell, CA 95008
408.379.3790
Fax 408.364.4013

Los Angeles
815 N. El Centro Avenue
Los Angeles, CA 90038
323.463.2119
Fax 323.463.2119

San Bernardino
572 N. Arrowhead Avenue, Suite 100
San Bernardino, CA 92401
909.266.2700
Fax 909.266.2710

Fresno
1630 East Shaw Avenue, Suite 150
Fresno, CA 93710
559.248.8550
Fax 559.248.8555

Sacramento
9343 Tech Center Drive, 2nd Floor
Sacramento, CA 95826
916.388.6400
Fax 916.649.7158

May 10, 2021

Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of the Community Services Agency (CSA), I write in support of the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021. As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police and emergency departments. For communities that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, and even result in a deadly experience. This new, innovative program will utilize a community-based approach in addressing behavioral health crisis calls as an alternative to law enforcement response.

We support the CMR programmatic elements: an onsite field team comprised of an emergency medical technician, crisis intervention worker, and peer outreach specialist, prevention-focused programming, family involvement component, accessibility of the program through a trusted phone line not associated with law enforcement, and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and North County.

As a safety net provider in North County, CSA is excited about the CMR program. We see community members in crisis regularly and we do the best we can to help, but there are plenty of times when the expertise of a mental health professional is needed. The CMR model, which is community- rather than law-enforcement-based, would enable us to offer a reassuring and excellent continuum of care to the populations we serve.

The CMR program was selected by MHSA stakeholders and supported by community members as an MHSA Innovation project based on its direct impact on marginalized communities, highly impacted by current issues of race equity and social justice in accessing behavioral health crisis services.

I urge you, especially during this time, to approve this project that will bring much-needed resources to Santa Clara County.

Sincerely,

Nicole Fargo Nosich, MSW
Associate Director
nfargonosich@csacares.org

CITY OF MOUNTAIN VIEW

Office of the Mayor and City Council • 500 Castro Street • Post Office Box 7540 • Mountain View, California 94039-7540
650-903-6305 • FAX 650-903-6039

May 11, 2021

Mental Health Services Oversight
& Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

LETTER OF SUPPORT OF THE COUNTY OF SANTA CLARA MHSA INNOVATION-15: COMMUNITY MOBILE RESPONSE PROGRAM

Dear Chair Ashbeck and Commissioners:

On behalf of the City of Mountain View, I am writing to express our support of the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021. This pilot program will significantly impact people's lives in Mountain View and the region by intervening with a wide range of mental health-related crises, relying on trauma-informed deescalation and harm reduction techniques.

As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police and emergency departments. For communities that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, and even result in a deadly experience. This new, innovative program will utilize a community-based approach in addressing behavioral health crisis calls as an alternative to law enforcement response.

We support the CMR programmatic elements: an on-site field team comprised of an emergency medical technician, crisis intervention worker, and peer outreach specialist, prevention-focused programming, family involvement component, accessibility of the program through a trusted phone line not associated with law enforcement, and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and North County.

The City supports this program because it has been proven that, for nonviolent and other lower-level calls for service, engaging the community with a health-focused and resource-connecting approach leads to better outcomes. Many cities throughout the country (including Denver, Albuquerque, and Portland) have begun piloting similar programs to address needs and to reduce the interaction between the public and law enforcement in

certain circumstances. For example, Denver's Support Team Assisted Response (STAR) unit responded to 748 incidents in the STAR unit's first six months, and no incident involved an arrest, nor escalation to a police response. Those 748 incidents would previously have required a law enforcement response, limiting the availability of sworn officers for other law enforcement duties. Of the 748 calls for service, 67% were related to homelessness. This type of program provides a human-centered approach to some of our community's most complex concerns.

During summer and fall 2020, the City Council explored law enforcement matters facing Mountain View through our Ad Hoc Subcommittee on Race, Equity, and Inclusion. This exploration involved various community listening forums on local policing and other meetings to hear from our community and review and discuss Mountain View policing data during public meetings. The need for non-law enforcement responses to mental health crises was one of our community's most prominent messages. The Mountain View policing data supports this need. In 2019, Mountain View Police Officers responded to more than 550 mental health-related calls. The City recognizes the benefit of a highly trained, licensed social worker with advanced training to connect with individuals in crisis. The Mental Health Alternative Response Pilot Program would be a significant new resource for our community.

The CMR program was selected by MHSA stakeholders and is supported by community members as an MHSA Innovation project based on the program's direct impact on marginalized communities, highly impacted by current issues of race, equity, and social justice in accessing behavioral health crisis services.

I urge you, especially during this time, to approve this project that will bring much-needed resources to Santa Clara County.

Sincerely,

Ellen

Ellen Kamei
Mayor

EK/CG/1/MGR/001-05-07-21L

cc: City Council

CM, ACM/COO, ATCM—Thomas, ATCM—Gilmore, PMA—Gaines

City of Palo Alto

Office of the Mayor and City Council

May 10, 2021

Mental Health Services Oversight & Accountability Commission (MHSOAC)
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of the City of Palo Alto, I write in support of the County of Santa Clara Mental Health Services Act (MHSA) Innovation-15: Community Mobile Response (CMR) program approved by the Santa Clara County Board of Supervisors on April 20, 2021. As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police. For people that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, or worse. This new, innovative program will utilize a community-based approach in addressing behavioral health crisis calls as an alternative to a law enforcement response. This better serves fellow community members in crisis and frees up law enforcement resources to address other needs.

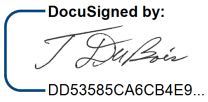
We support the CMR programmatic elements: an onsite field team comprised of an emergency medical technician, crisis intervention worker, and peer outreach specialist, prevention-focused programming, family involvement, program accessibility through a trusted phone line not associated with law enforcement, and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and Northern Santa Clara County.

The City of Palo Alto, residents of North County, and all of Santa Clara Country will benefit from this innovative program to ensure that responses to calls for service are resourced appropriately. The CMR program design, driven by significant community support, is modeled after successful programs in other jurisdictions, notably Eugene, Oregon and Denver, Colorado. The ability to have a non-law enforcement alternative response to calls for service will complement, and complete, the spectrum of available resources in Santa Clara County. A dedicated field team for North County will respond in a prompt manner to critical calls for service where seconds can make all the difference. The City of Palo Alto looks forward to working with the County of Santa Clara to facilitate the successful implementation of this innovative CMR program.

The CMR program was selected by MHSA stakeholders and supported by community members all throughout the County as an MHSA Innovation project based on its direct impact on marginalized groups, including our unhoused neighbors. As we seek to advance racial equity and social justice efforts, these behavioral health crisis services are paramount.

I ask for your support and approval of this program bringing much-needed mental health resources to Santa Clara County.

Sincerely,



Tom DuBois
Mayor, City of Palo Alto

cc: City Council, Palo Alto
Sherri Terao, Director, Santa Clara County Behavioral Health Department

P.O. Box 10250
Palo Alto, CA 94303
650.329.2477
650.328.3631 fax

MENTAL HEALTH SYSTEMS INC.

May 11, 2021

Mental Health Services Oversight & Accountability Commission

1325 J Street, Suite 1700

Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of Mental Health Systems Inc. , I write in support of the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021. As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police and emergency departments. For communities that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, and even result in a deadly experience. This new, innovative program will utilize a community-based approach in addressing behavioral health crisis calls as an alternative to law enforcement response.

This would be a great trauma informed alternatve for our Santa Clara ACT team to collaborate with.

We support the CMR programmatic elements: an onsite field team comprised of an emergency medical technician, crisis intervention worker, and peer outreach specialist, prevention-focused programming, family involvement component, accessibility of the program through a trusted phone line not associated with law enforcement, and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and North County.

The CMR program was selected by MHSA stakeholders and supported by community members as an MHSA Innovation project based on its direct impact on marginalized communities, highly impacted by current issues of race equity and social justice in accessing behavioral health crisis services.

I urge you, especially during this time, to approve this project that will bring much-needed resources to Santa Clara County.

Sincerely,

DocuSigned by:
Dolores Garcia
5ACCE60F26B7490...

Dolores Garcia

Santa Clara ACT

Project Safety Net (PSN) mobilizes community support and resources in Palo Alto for youth suicide prevention and mental wellness. We are a coalition working on community education, outreach, and training; access to quality youth mental health services; and policy advocacy.

May 11, 2021

Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of Project Safety Net (PSN), we strongly support the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021 and urge the MHSOAC approval. PSN (www.psnpaloalto.org) is a collective impact representing nearly 50 youth serving organizations, behavioral health providers, educators, policymakers, academia, and community members, including young people and their families. PSN came together ten years ago to advance youth wellbeing, mental health, suicide prevention, and resiliency.

CMR is an alternative mobile program to serve community members who are reticent of government mental health services and law enforcement to de-escalate crisis situations. The service is not limited only to residents, but to those who work, study and worship in the three regions: San Jose, Gilroy, and North Santa Clara County.

While there are several mobile behavioral health services throughout the state, the community-centered County of Santa Clara's CMR model is innovative for the following reasons:
1) focuses on prevention as much as crisis;
2) care provided by established community-based behavioral health organizations with firsthand understanding of culture and established trust of the communities that they will serve;
3) response team integrates peer specialists with lived behavioral health experience and look like the diverse community that they will serve; and
4) explores a financial sustainability model that partners with local municipalities to "buy-in" to increase access to mobile services and strengthen evaluation.

While PSN is dedicated to starting with the youth community first, our collective impact is committed to supporting its community partners that serve young people and their families throughout Santa Clara County. PSN looks forward to the opportunity to support the County of Santa Clara and coordinate efforts among PSN partners to strengthen community mental health efforts, especially in response to the impact of COVID-19 pandemic and racial health disparities. Please do not hesitate to contact me at (650) 329-2330 or mary@psnyouth.org, if you have questions or can offer more information.

With appreciation,

Mary Cheryl B. Gloner, MPH, MBA
Chief Executive Officer

Starlight
Community Services
1885 Lundy Ave., Ste. 223
San Jose, CA 95131

Ph: 408 284-9000
FAX: 408 284-9073

May 11, 2021

Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear MHSOAC Commissioners,

On behalf of Starlight Community Services, I write in support of the County of Santa Clara MHSA Innovation-15: Community Mobile Response (CMR) program approved by the County Board of Supervisors on April 20, 2021. As described in the County's Draft Plan document for this new program, individuals experiencing mental health crises often interact with police and emergency departments. For communities that are historically unserved, underserved, or inappropriately served, interacting with law enforcement can be frightening, distressing, and even result in a deadly experience. This new, innovative program will utilize a community-based approach in addressing behavioral health crisis calls as an alternative to law enforcement response.

We support the CMR programmatic elements: an onsite field team comprised of an emergency medical technician, crisis intervention worker, and peer outreach specialist, prevention-focused programming, family involvement component, accessibility of the program through a trusted phone line not associated with law enforcement, and a community collaborator embedded in the three service locations for this new program: San Jose, Gilroy, and North County.

Starlight has provided community-based services to at risk youth and families and has witnessed police response to mental health crisis and have been asked by our consumers to not utilize the police. Sometimes there is no other alternative so a CMR would benefit not only our consumers but every consumer in Santa Clara County.

The CMR program was selected by MHSA stakeholders and supported by community members as an MHSA Innovation project based on its direct impact on marginalized communities, highly impacted by current issues of race equity and social justice in accessing behavioral health crisis services.

I urge you, especially during this time, to approve this project that will bring much-needed resources to Santa Clara County.

Sincerely,

Cheryl Engelstad, MFT
Intensive Outpatient Director
Starlight Community Services
cenegelstad@starsinc.com
www.starsinc.com

Organizational Signatories
AACI
Abode Services
African American Community Services Agency
Alum Rock Counseling Center
Asian American Recovery Services, a program of HealthRIGHT 360
Behavioral Health Contractors' Association (BHCA)
Bill Wilson Center
Black Leadership Kitchen Cabinet
Catholic Charities of Santa Clara County
City Year
Community Health Partnership
Community Solutions
Gardner Health Services
Guadalupe River Park Conservancy
H.E.R.O. Tent
Horizon Services
Indian Health Center of Santa Clara Valley
International Children Assistance Network (ICAN)
Jewish Family Services of Silicon Valley
Lighthouse of Hope Counseling Center
Mekong Community Center Inc
Momentum for Health
NAMI Santa Clara County
National Compadres Network
Next Door Solutions to Domestic Violence
Parents Helping Parents, Inc.
Parisi House on the Hill
PATH (People Assisting The Homeless)
Pathway Society, Inc.
Peninsula Family Service
Peninsula Healthcare Connection
Planned Parenthood Mar Monte
Project MORE
Project Safety Net, Inc.
Project Sentinel
Recovery Cafe San Jose
RECS
Sacred Heart Community Service
San Jose Nikkei Resisters
San Jose Taiko
San Jose/Silicon Valley NAACP
Santa Clara County
Santa Clara University
Silicon Valley Council of Nonprofits
Silicon Valley De-Bug
SJSU Human Rights Institute
SOMOS Mayfair
St. Joseph's Family Center
TEYA (Teachers Empowering Youth Activists)
Ujima Adult and Family Services
Uplift Family Services
Working Partnershuips USA
Youth Community Service

May 11, 2021

Commissioners
The Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioners:

As leaders in Santa Clara County we write to express our support for Santa Clara County's MHSA INN-15 Project and urge you to approve it when it comes before the MHSOAC.

Our community came together in June 2020 concerned about the number of officer encounters around the nation that have ended in avoidable tragedies. The Community Mobile Response program will not only have an important impact on Santa Clara County, but also tests a new model that can potentially serve as a resource for many other communities across the State.

We look to the police not just to enforce laws but also to respond to calls related to a variety behavioral health needs including mental health, substance use, homelessness, truancy, family conflict, and welfare checks. Last summer, our community sent a clear message to our elected leaders: We must reduce the level of police response to these emergency calls that are not criminal in nature. Diverting these calls to professionals and peers solely focused on the actual needs of the individuals involved will avoid excessive uses of force, incarceration, injury and, in worst cases, death. Santa Clara County's MHSA INN-15 creates a Community Mobile Response Program--a trauma informed and community rooted approach to respond and best meet the needs of adults experiencing a crisis.

In situations where a person in crisis fears or does not trust police the situation can escalate when an officer responds. Racial bias also plays a significant role as police officers are historically more likely to use excessive force when responding to Black residents and other people of color. Cultural differences can also affect the type of care certain people receive when interacting with family members as well as creating distrust or misunderstandings when police officers get involved. When community-based crisis counselors and peers—the personnel to be employed by the Community Mobile Response--

respond to an individual in crisis, the person is more likely to accept help and the crisis de-escalates.

The Community Mobile Response model also includes important components of follow-up after the crisis to connect individuals with services and prevent future crises, as well as facilitating on-going community input and education. That feature leverages the many assets in neighborhoods across the County. This alternative community response was created by reviewing and studying several models being developed throughout the United States and receiving much input from the community.

We pledge to engage in a community-wide effort to train Santa Clara County residents to reach out to the new Community Mobile Crisis as an alternative to law enforcement. Please give us the opportunity to do so by approving Santa Clara County's INN-15 Project.

Milan R. Balinton
Executive Director
African American Community Services Agency

Alma Burrell
Co-Chair
Black Leadership Kitchen Cabinet

Poncho Guevara
Executive Director
Sacred Heart Community Service

Jethroe Moore II
President
San Jose/Silicon Valley NAACP

Raj Jayadev
Executive Director
Silicon Valley De-Bug

William Armaline
Director
SJSU Human Rights Institute

Camille Llanes-Fontanilla
Executive Director
SOMOS Mayfair

Yvonne Maxwell
Executive Director
Ujima Adult and Family Services

Sparky Harlan
CEO
Bill Wilson Center

David K. Mineta
President and CEO
Momentum for Health

Don Taylor
Regional Executive Director
Uplift Family Services

Sarita Kohli
CEO
AACI

Dolores Alvarado
CEO
Community Health Partnership

Gary l. Montrezza
CEO
Pathway Society, Inc.

Greg Kepferle
CEO
Catholic Charities of Santa Clara County

Heather Cleary
CEO
Peninsula Family Service

Kyra A Kazantzis
CEO
Silicon Valley Council of Nonprofits

Lana Nguyen
CFO
MEKONG COMMUNITY CENTER INC

Louis Chicoine
CEO
Abode Services

Lisa lee Davis
COO
Community Solutions

Long Vu
CEO
MEKONG COMMUNITY CENTER INC

Mary Gloner
CEO
Project Safety Net, Inc.

Reymundo C. Espinoza
CEO
Gardner Health Services

Steve Eckert
CEO
Alum Rock Counseling Center

Sonya M. Tetnowski
Chief Executive Officer
Indian Health Center of Santa Clara Valley

Joel John Roberts
CEO
PATH (People Assisting The Homeless)

Ann Marquart
Executive Director
Project Sentinel

Cheri Greven
Interim Vice President of Public Affairs
Planned Parenthood Mar Monte

Christy Hayes
Executive Director
Horizon Services

David Cox
Executive Director
St. Joseph's Family Center

Elisa Koff-Ginsborg
Executive Director
Behavioral Health Contractors' Association (BHCA)

Esther Peralez-Dieckmann
Executive Director
Next Door Solutions to Domestic Violence

Gloria Baxter, LCSW
Executive Director
Lighthouse of Hope Counseling Center

Héctor Sánchez-Flores
Executive Director
National Compadres Network

Jason Su
Executive Director
Guadalupe River Park Conservancy

Jon Pedigo
Director Of Advocacy And Community Engagement
Catholic Charities Of Santa Clara County

Kathy Cordova
Executive Director
Recovery Cafe San Jose

Leif Erickson
Executive Director, retired
Youth Community Service

Lorraine Zeller
Behavioral Health Board Member
County of Santa Clara

Maria Daane
Executive Director
Parents Helping Parents, Inc.

Marissa Martinez
Communications + Fund Development Specialist
SVCN

Mindy Berkowitz
Executive Director
Jewish Family Services of Silicon Valley

Mora Oommen
Executive Director
Youth Community Service

Miguel Valencia
Director of Behavioral Health Services
Gardner Health Services

Pat Mitchell
Executive Director
Parisi House on the Hill

Pete Settelmayer
Executive Director
City Year

Quyen Vuong
Executive Director
International Children Assistance Network (ICAN)

Razelle Buenavista
Managing Director
Asian American Recovery Services, a program of HealthRIGHT 360

Rovina Nimbalkar
Executive Director
NAMI Santa Clara County

Brandon Roul
Community Organizer
Sacred Heart Community Service

Tomara Hall
Founder of TEYA; Special Education Teacher; Equity Leader; Community Organizer
TEYA (Teachers Empowering Youth Activists)

Wisa Uemura
Executive Director
San Jose Taiko

Derrick Sanderlin
Community Organizer
Sacred Heart Community Service

Akemi Flynn
Member
San Jose Nikkei Resisters

Andrew Rodriguez
RECS

Bob Brownstein
Strategic Advisor
Working Partnershuips USA

Chantal Shaffer
RECS Committee Member
Sacred Heart Community Service

Kiana Simmons
President
H.E.R.O. Tent

Yvonne Maxwell
Executive Director
Ujima Adult and Family Services

Debra Dobosz
Registered Nurse
Santa Clara County

Heather Boddie-Russo, LCSW
Program Director
Peninsula Healthcare Connection

Helen L Kassa
Policy & Advocacy Coordinator
African American Community Services Agency

Azita Shakib
Ms.
RECS

Joshua Shannon
Educator
Santa Clara University

Nathan Svoboda
President
Project MORE

Rachel Hileman
QA/QI Manager
Peninsula Healthcare Connections - New Directions

Sandra Asher
Disability Advocate
Sacred Heart Community Service

Tina L Sentner
Program Director
Horizon Services, Inc. - Mission Street Sobering Center

AGENDA ITEM 5

Action

May 27, 2021 Commission Meeting

Marin County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Marin County's request to fund the following new Innovative project:

1. **From Housing to Healing, Re-Entry Community for Women**

Marin County is requesting up to $1,795,000 of Innovation spending authority over five years to establish a supportive services/housing program, designed to address severe mental illness, adverse childhood experiences (ACEs), a screening tool for childhood trauma, and substance use disorders in women, including transwomen, after their release from jail.

The Housing to Healing Re-entry Community for Women will house recently released female inmate, trans-inclusive, in a safe environment while helping them to understand how their adverse childhood experiences (ACEs) may have contributed to their mental illness, substance use and/or incarceration. This housing program, however, is more than just a place for women to live; it is designed to be a holistic, healing centered community, with various alternative treatments and modalities designed to assist the women with understanding, addressing, and managing the effects of their mental illness including traumatic events and elevated ACEs scores.

Marin County reports that it is currently using a series of care coordination programs to prevent recidivism, through Proposition 47 funding. While somewhat effective, programs such as collaborative courts, Pathways Mental Health Court, implementation of low barrier care coordination programs, enhanced jails and custody services/programs do not focus on the childhood traumas that increase the risk of re-incarceration nor do they address individuals with previous histories of abuse, neglect and/or mistreatment.

What differentiates this program from the Proposition 47 programs is that it will focus on remediating the trauma through somatic therapies. *(Somatic Therapy describes any practice that uses the mind-body connection to help you survey your internal self and listen to signals your body sends out about areas of pain, discomfort, or imbalance).*

By housing women with similar traumatic experiences in a safe place while providing therapeutic support to ameliorate past experiences will help establish a community of support and successful re-entry into the community for women suffering from a severe mental illness and criminal justice involvement.

This consumer-led innovation and variety of interventions used in this project invites members of the house to participate in the modalities that they are interested in, and then will report on those treatments they find most successful after utilizing them.

The County's public comment period was held between March 13, 2021 through April 13, 2021. No comments were received prior to the hearing and all comments made during the hearing were positive and supportive (pages 15-16 of project plan). The Mental Health Board approved the plan on April 13, 2021 and it is anticipated that the plan will be presented (and approved) by the Board of Supervisors in their June 2021 meeting, after Commission approval.

Commission staff originally shared this project with its six stakeholder contractors, listserv and the two Commission committees (CFLC and CLCC) on March 16, 2021 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared on April 21, 2021.

One letter expressing support from the Chair of the Marin County Mental Health Board was received and is included here as a reference.

Enclosures (3): (1) Biography for Marin County's Innovation Presenter; (2) Staff Analysis: From Housing to Healing, Re-entry Community for Women; (3) Letter of Support

Handout (1): PowerPoint Presentation: From Housing to Healing, Re-entry Community for Women

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

From Housing to Healing, Re-entry Community for Women:

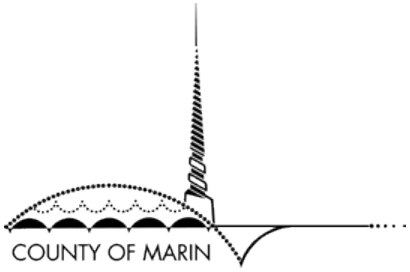
https://mhsoac.ca.gov/sites/default/files/Marin_INN_Plan_Housing%20to%20Healing.pdf

Proposed Motion: The Commission approves Marin County's Innovation plan, as follows:

Name: From Housing to Healing, Re-entry Community for Women

Amount: Up to $1,795,000 in MHSA Innovation funds

Project Length: Five (5) Years



County of Marin Presentation for Innovation Proposal:
From Housing to Healing, A Re-Entry Community for Women

Taffy Lavié, County of Marin
Administrative Assistant II

As I'm coming up on my 16-year clean date in October, I can't help but remember what my life was like living on the streets of San Rafael: isolated away from all my family, in and out of county jail before spending 4 years in prison. Having no place to go every time I got out of jail was the reason for my repeated failure.

I was raised in Marin County by my Mom and my Dad who was a San Rafael police officer for 40 years. I made a few bad choices along the way and ended up isolated away from my family, friends and everyone that mattered to me. I barely made it out—but frankly, I was one of the lucky ones. Everyone I was with while I was using and homeless is now either in prison for many years or has overdosed and died.

Today I work for the County of Marin in the Behavioral Health and Recovery Services Division where I have come full circle. I can't think of a more fulfilling place for me to be than working for the department that supports the many county services that helped me find my way.

Every day, I try to give back as much as I can; my favorite is bringing Narcotics Anonymous meetings into the women's pod of the Marin County Jail. I always love to talk about the importance of the in-custody services. Being in custody was always my window of time to be able to hear about another way of living, getting well and finding my smile. Back then there was no bridge for me to be able to take what I learned in jail and make that life a reality when I got out. It seemed impossible and hopeless. Now it seems there may be hope on the horizon, which is what brings me here today. This program is that connection, that bridge, that I needed then, and now will save more women.

Not only do I have an amazing job today, but I have a group of lifelong friends and an incredible support system and a smile on my face. Finally, real support; a real smile. My hope is to now be part of helping others along their journey and tell them treatment is effective and people do recover.

STAFF ANALYSIS - MARIN COUNTY

Innovation (INN) Project Name:	**Housing to Healing, Re-Entry Community for Women**
Total INN Funding Requested:	**$1,795,000**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**May 27, 2021**

Review History:

Approved by the County Board of Supervisors:	Pending MHSOAC Approval
Mental Health Board Hearing:	April 13, 2021
Public Comment Period:	March 13, 2021-April 13, 20121
County submitted INN Project:	March 13, 2021
Date Project Shared with Stakeholders:	March 16, 2021 and April 21, 2021

Project Introduction:

Marin County is requesting up to $1,795,000 of Innovation spending authority to establish a supportive services/housing program, designed to address severe mental illness, adverse childhood experiences (ACEs), a screening tool for childhood trauma, and substance use disorders in women, including transwomen, after their release from jail. The alternative and varied treatment modalities offered will build necessary skills to support the women to be successful upon reentry to the community post incarceration.

The *Housing to Healing* Re-entry Community for Women will house recently released female inmate, trans-inclusive, in a safe environment while helping them to understand how their adverse childhood experiences (ACEs) may have contributed to their mental illness, substance use and/or incarceration. This housing program, however, is more than just a place for women to live; it is designed to be a holistic, healing centered community, with various alternative treatments and modalities designed to assist the women with understanding, addressing, and managing the effects of their mental illness including traumatic events and elevated ACEs scores.

What is the Problem?

The County reports that women in jail typically have experienced more emotional and physical trauma than the general population (page 3 of project plan).

Traditional methods of treating the effects of these traumas—including medications, abstinence from illicit substances or talk therapy have not been effective for two reasons:

1. **Treatments are diagnosis specific**
2. **Talk therapies rely on a person's ability to mentally recall and access these traumas, which may result in re-traumatization and/or re- incarceration.**

In a 2018 study (See Footnote 3, Marin County document, page 3), 214,000 persons from the jail general population were interviewed and 17.8% of the women scored 4 or higher for ACEs. In 2020, Marin County partnered with local nursing students with the County Jail's Mental Health Team and interviewed inmates for ACEs and found that 53.3% of the women in jail had a score of 4 or more ACEs and 26.7 % of those women had a score of 7 or higher.[1] Children, adolescents, and adults with ACE scores of 7 and above show increases in suicide attempts, and with scores of 6 or more, are more likely to die 20 years earlier than persons without ACE histories.

Marin County reports that it is currently using a series of care coordination programs to prevent recidivism, through Proposition 47 funding. Even still, its recidivism rate is at 10% following the first 12 months of release. While somewhat effective, programs such as collaborative courts, Pathways Mental Health Court, implementation of low barrier care coordination programs, enhanced jails and custody services/programs do not focus on the childhood traumas that increase the risk of re-incarceration nor do they address individuals with previous histories of abuse, neglect and/or mistreatment (p. 4).

What differentiates this program from the Proposition 47 programs is that it will focus on remediating the trauma through somatic therapies: working with the physical manifestations of trauma, and other modalities.

Note: Somatic Therapy describes any practice that uses the mind-body connection to help you survey your internal self and listen to signals your body sends out about areas of pain, discomfort, or imbalance.

Further, by housing women with similar traumatic experiences in a safe place while providing therapeutic support to ameliorate past experiences will help establish a community of support and successful re-entry into the community for women suffering from a severe mental illness and criminal justice involvement.

<u>How this Innovation project addresses this problem:</u>

The County is proposing to create a housing program for women including transgender that will focus on addressing trauma experienced by these women rather than more traditional methods of diagnosis/treatment, even though the diagnosis will still be considered to inform the treatment plan and alternative treatment modalities. Potential

[1] http://traumadissociation.com/ace

participants for this project will be interviewed while still incarcerated and participation will be based on a referral to the housing program. Interview and placement criteria will be based on the woman's ACEs score. Participants in this project will be part of a community that is focused on successful trauma-informed somatic practices to assist them with developing coping skills, increasing tolerance and learning self-acceptance. The women in the house will be provided with linkages to services related to ongoing or more permanent housing and employment. "Alumni" of the program will participate as both paid and voluntary peers. In fact, a peer will serve as a housing manager (paid) and alumni will also serve on the project advisory board and will be invited to return for community dinners.

This consumer-led innovation and variety of interventions used in this project invites members of the house to participate in the modalities that they are interested in, and then will report on those treatments they find most successful after utilizing them.

Community Program Planning Process CPPP): (see pgs 10-13 in project plan)

Local Level

The County conducted an online request for potential ideas and 14 ideas were submitted by various community members and "coalitions" (see p. 10 of project plan). A Lived Experience Advisory group (comprised of nine members with various backgrounds, recovery, mental health, and substance use challenges), then reviewed these ideas and conducted a meeting on February 21, 2021 to discuss and score the proposals.

Proposals were rated based on responses to various questions for the community. Based on the ranking and scoring of the proposals, the highest-ranking score was issued for a proposal named "Trauma, the Elephant in the Room", which ultimately was developed into this proposal "From Housing to Healing, Re-entry Community for Women". The proposal for Housing to Home was developed and vetted through the community review process. The County held their Public comment between March 13, 2021 through April 13, 2021. No comments were received prior to the hearing and all comments made during the hearing were positive and supportive (pages 15-16 of project plan). The Mental Health Board approved the plan on April 13, 2021 and it is anticipated that the plan will be presented (and approved) by the Board of Supervisors in their June 2021 meeting, after Commission approval.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors, listserv and the two Commission committees (CFLC and CLCC) on March 16, 2021 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared on April 21, 2021.

One letter expressing support from the Chair of the Marin County Mental Health Board was received and will be included as a reference.

Learning Objectives and Evaluation:

The County estimates that it will serve six (6) women in the first year and that participants will increase by eight (8) participants each year, which includes alumni of the program remaining involved. At the end of this five-year project duration, the County estimates that 38 women will be served directly (residing at some point in the house) and another 100 women will be participants in various somatic or alternative therapies recommended by the house residents.

The target population will be women, trans-inclusive, diagnosed with serious mental illness and possible co-occurring disorders, who have been incarcerated or in a locked facility who have high ACEs scores (p. 6).

Marin County believes that creating a program to address women's trauma will result in:

1. Successful completion of a residential program (i.e., moving on to permanent housing, employment, etc.),
2. Decrease in re-incarceration
3. Increase in housing stability and a feeling of well-being (p. 8).

The County will define and determine somatic therapies that are most effective for women with ACEs based on recommendations and experiences of the participants of this program and determine how these therapies can be used throughout the behavioral health and homeless communities.

The County plans to contract with an evaluator to develop a more formal evaluation plan and methodology. The County anticipates that by assessing the women's historical background (medical, psychological, social, and legal) and who are considered for the program will allow for an established reliable baseline for evaluating the success of this program. Further, the County will be utilizing The Flourishing Scale (FS, p. 9 of project plan) for participants every 6 months to establish any increases in overall wellbeing.

The county has identified two learning goals:

1. Does centering the program on healing and addressing trauma result in higher rates of successful stabilization, decreased recidivism, increased housing stability, and increased feelings of psychological wellbeing?
    a. This will be measured by using the Flourishing scale cited above.

2. What somatic therapies are the most successful with this group of women and how can that be spread throughout the Behavioral Health and homelessness systems of care?
    a. This will be measured by tabulating and evaluating participants' preferences and based on those responses, will then determine the most successful therapies.

The Budget

Funding Source	FY 21/22* Jan 22-Jun 30 (6 months)	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27* July 1-Dec 31 (6 months)	TOTAL
Innovation Funds	$ 229,587	$320,827	$322,557	$337,383	$363,158	$ 221,488	$1,795,000
Medi-Cal FFP	$ 45,796	$ 94,340	$ 97,171	$100,087	$103,088	$ 53,090	$ 493,572
1991 Realignment							$ -
Any other funding							$ -
Total Project Amount							$2,288,572

5 Year Budget	FY 21/22 Jan 22-Jun 30 (6 months)	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27 July 1-Dec 31 (6 months)	Total
Personnel	$ 33,163	$ 68,316	$ 70,365	$ 72,475	$ 74,650	$ 38,445	$ 357,414
Direct Costs	$ 129,000	$208,474	$207,928	$218,708	$238,948	$ 152,328	$1,155,386
Indirect Costs	$ 24,324	$ 41,518	$ 41,744	$ 43,678	$ 47,040	$ 28,616	$ 226,920
Non-recurring costs	$ 41,000	$ -	$ -	$ -	$ -	$ -	$ 41,000
Other Expenditures	$ 2,100	$ 2,520	$ 2,520	$ 2,520	$ 2,520	$ 2,100	$ 14,280
							$ -
Total	$ 229,587	$320,828	$322,557	$337,381	$363,158	$ 221,489	$1,795,000

*** Total 5 year project duration; however, first FY and last FY of project are only 6 months long**

The County is requesting authorization to spend up to $1,795,000 in MHSA Innovation funding for this project over a period of five years.

- Personnel costs, including employee benefits, direct and indirect costs for a 1.0 FTE Trauma Therapist in the amount of $508,890 (excludes FFP offset of approximately $493,572) represents 28% of the total MHSA budget.
- Total operating costs in the amount of $834,080 represents 46% of the budget and includes house rent, and utilities, a .5 FTE housing/support manager, PEER stipends, activity, nutrition, vehicle maintenance, direct and indirect costs.
- Non-recurring costs in the amount of $41,000 represent .02% of the total costs
- Evaluation and other contract costs in the amount of $396,750 represent 22% of the total MHSA budget.
- Finally, other expenditures (stipends and indirect costs for stipends for stakeholder representatives) in the amount of $14,280 represent .007% of the total MHSA budget.

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

References:

https://www.healthline.com/health/somatics#What-does-that-even-mean?

RACHEL FARAC [redacted]

To: Mental Health Services Oversight and Accountability Commission

From: Rachel Farac, Chair of the Marin County Mental Health Board

Date: May 2, 2021

Re: Marin County Innovation Proposal: From Housing to Healing

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Dear Commissioner,

I am writing on behalf of the Marin County Mental Health Board and a community member.

As a board, we fully support this wonderful, innovative project. The adverse childhood experiences (ACE) study has shown that 53% of the Women's Marin County Jail Mental Health population has experienced 4or more adverse childhood experiences. This statistic is three times higher than the general population. We must address this issue, and " From Housing to Healing" does precisely that.

The board is impressed by the thorough, comprehensive plan which will address trauma at the focal point. We need to take mental health seriously, and this is an innovative solution where there has been a gap in treatment. The Mental Health Board recommends you vote in favor of this proposal.

As a community member, I favor this proposal and believe it will significantly impact their lives. Women tend to be more social and need a supportive community, and this program does just that.

Please feel free to contact me via phone or email with any questions. Thank you.

Rachel Farac
Chair of the Marin County Mental Health Board

AGENDA ITEM 6

Action

May 27, 2021 Commission Meeting

Legislative Priorities

Summary: The Commission will consider legislative and budget priorities related to Commission initiatives, including Senate Bill 465 (Eggman) for the current legislative session.

Background:

Senate Bill 465 (Eggman)

Community Services & Support (CSS) is the largest component of the Mental Health Services Act. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Currently, counties are required to set aside at least half of the CSS funds for Full Service Partnerships (FSP) programs. Full Service Partnerships represent a $1 billion annual investment in the highest level of voluntary, community-based, recovery-oriented care available in California. Strengthening this approach remains one of the most promising pathways to reducing negative outcomes.

This bill requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to report to the Legislature each year on how FSPs are meeting the goal of serving Californians most in need of the intensive, wraparound care that FSPs provide, and how the programs may be improved to reduce the high prevalence of homelessness, criminalization, and hospitalization for those experiencing severe mental illness. The bill would also expand the eligibility for MHSA-funded services to an increased pool of children who would qualify for and benefit from those services.

SB 465 could strengthen the Commission's current work to evaluate Full Services Partnership data linkage projects . The Commission over the last two years has analyzed state-held data on Full Service Partnerships and arrests. The analysis reveals that 70 percent of FSP clients had record of arrest for the year before enrollment, during enrollment, or for the year after exit. Among those with prior arrests, FSP participation was associated with significantly reduced rearrests.

FSP outcomes also vary across counties. In some counties, some 40 percent of FSP consumers report meeting goals upon program exit, while in other counties 10 percent or fewer exiting enrollees reported having met their goals upon exiting. Less is known about how well FSPs address unemployment, homelessness and unnecessary hospitalizations,

but the potential for high-performing FSPs to reduce those adverse outcomes appears significant.

Enclosed for your review is information regarding Senator Eggman's plan to expand the eligibility criteria for children for MHSA funded services in order to prevent more severe outcomes later in life.

Presenter: David Stammerjohan, Chief of Staff, Office of Senator Eggman

Enclosures (4): (1) Senate Bill 465 (Eggman); (2) Senate Appropriations Committee bill analysis; (3) SB 465 Fact Sheet; and (4) MHSOAC Legislative Tracking Chart.

AMENDED IN SENATE APRIL 26, 2021

AMENDED IN SENATE MARCH 8, 2021

SENATE BILL No. 465

Introduced by Senator Eggman

February 16, 2021

An act to amend Section 5600.3 of, and to add Section 5845.8 to, the Welfare and Institutions Code, relating to mental health, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 465, as amended, Eggman. Mental health.

(1) Existing law contains provisions governing the operation and financing of community mental health services in every county through locally administered and locally controlled community mental health programs. Existing law further provides that, to the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve specified target populations, including, among others, seriously emotionally disturbed children and adolescents.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs and requires counties to spend those funds as specified, including on the target population of seriously emotionally disturbed children and adolescents.

Existing law defines "seriously emotionally disturbed children and adolescents" for the above purposes to include minors under 18 years of age who have a mental disorder, other than a primary substance use

disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms and who meets one or more of the prescribed criteria. One of those criteria is that, as a result of the mental disorder, the child has substantial impairment in at least 2 specified areas and is either at risk of removal from the home or has been removed from the home or the mental disorder has been present for more than 6 months or is likely to continue for more than a year without treatment.

This bill, instead, would make substantial impairment in 2 of the required areas or being at risk of removal from the home or having been removed from the home separate criteria for determining serious emotional disturbance. *The bill would prohibit removal from the home, or risk of removal from the home, from being used as the sole determinant of a child being seriously emotionally disturbed.* This bill would make an appropriation by expanding the target population for which continuously appropriated MHSA moneys may be spent.

(2) The MHSA, in addition to funding a system of community mental health services, also establishes the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the act.

This bill would require the commission to report to specified legislative committees the outcomes for people receiving community mental health services under a full service partnership model, as specified, including any barriers to receiving the data and recommendations to strengthen California's use of full service partnerships to reduce incarceration, hospitalization, and homelessness.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares that state regulations require counties to direct the majority of their Mental Health Services Act Community Services and Supports funds to full service partnerships, as defined in Section 3260 of Title 9 of the California Code of Regulations. Programs in this category provide flexible funding, intensive case management, and services such as housing, employment, education, peer support, cooccurring disorder treatment, and outreach. However, the full service partnership category of services could be strengthened to better

serve the most needy, at-risk individuals, with an emphasis on serving those at risk of experiencing homelessness, hospitalization, or criminalization. Revisions to the current regulatory definitions and requirements of the full service partnership program will allow counties to better serve children, adults, and older adults with mental illness.

SEC. 2. Section 5600.3 of the Welfare and Institutions Code is amended to read:

5600.3. To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a) (1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under 18 years of age who have a mental disorder identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community.

(B) The child is at risk of removal from home or has already been removed from the home. *Removal or risk of removal from home on its own does not qualify a child as seriously emotionally disturbed.*

(C) The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.

(D) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

(b) (1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, that may cause behavioral functioning which interferes substantially with the primary activities of daily living, and that may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section does not exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder, developmental disorder, or acquired traumatic brain injury as defined in subdivision (a) of Section 4354, unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities, including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services, but the eligible veteran shall not be denied county mental or behavioral health services while waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the United States Department of Veterans Affairs.

(A) An eligible veteran shall not be denied county mental health services based solely on the person's status as a veteran, including whether or not the person is eligible for services provided by the United States Department of Veterans Affairs.

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.

(c) Adults or older adults who require, or are at risk of requiring, acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

SEC. 3. Section 5845.8 is added to the Welfare and Institutions Code, to read:

5845.8. (a) The commission shall annually report to the Senate and Assembly Committees on Health, Senate Budget Subcommittee

on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services the outcomes for those receiving community mental health services under a full service partnership model.

(b) The report shall include, but not be limited to, information regarding persons eligible for full service partnerships, including summary information relating to enrollees and nonenrollees with respect to the community mental health services they receive and their experience with all of the following:

(1) Incarceration or criminalization.

(2) Housing status or homelessness.

(3) Hospitalization, emergency room utilization, and crisis service utilization.

(c) The report shall also include information regarding individuals who separate from a full service partnership, including, but not limited to, analysis of the reasons for separation and, to the extent possible, the community mental health services received and the statuses or experiences of these individuals regarding the outcomes identified in subdivision (b) for a period of 12 months following separation.

(d) The report shall also assess the degree to which the individuals most in need are accessing services and maintaining participation in a full service partnership or other programs providing similar services.

(e) The commission shall report any barriers to receiving the data relevant to completing this report and include recommendations to strengthen California's use of full service partnerships to reduce incarceration, hospitalization, and homelessness.

(f) In doing this work, the commission shall consult with the California mental health community, including, but not limited to, consumers, relatives of consumers, providers, and other subject matter experts.

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SENATE COMMITTEE ON APPROPRIATIONS
Senator Anthony Portantino, Chair
2021 - 2022 Regular Session

SB 465 (Eggman) - Mental health

Version: April 26, 2021
Urgency: No
Hearing Date: May 10, 2021

Policy Vote: HEALTH 11 - 0
Mandate: No
Consultant: Karen French

Bill Summary: Broadens the definition of "seriously emotionally disturbed (SED) children or adolescents" in the Bronzan-McCorquodale Act relative to funding community mental health services. Requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to report annually to the Legislature specified information about services and outcomes for those receiving Mental Health Services Act-funded Full-Service Partnership services.

Fiscal Impact:

- MHSOAC reports annual costs of $350,000-$400,000 (General Fund) See Staff Comments below for more details.

Background: According to the author, the sad reality of many of our neighbors living on the streets while dealing with mental illness tells us that we must make better use of the resources available to help these Californians. Estimates by the Treatment Advocacy Center are that as many as one-third of California's population experiencing homelessness are also living with a serious mental illness. That could mean, even conservatively, tens of thousands of those living houseless in the community are also experiencing a likely untreated or undertreated mental illness. Recent reporting by CalMatters uses state data indicating up to one-third of incarcerated Californians live with documented mental illness. The historical arc of people who experience homelessness or incarceration provides ample evidence of missed opportunities to intervene and provide effective treatment, thereby reducing these outcomes. Early intervention is critical and must start at a much earlier age. This bill expands the eligibility criteria for children for MHSA-funded services in order to prevent more severe outcomes later in life. It would also require the MHSOAC to report to the Legislature the outcomes from Full Service Partnerships (FSPs); how they are serving those who are hospitalized, criminalized, and experiencing homelessness; and make recommendations on how FSPs may be improved to better serve these populations.

Proposed Law:

1) Broadens the definition of "SED children or adolescents" by:

a) Repealing the requirement in existing law that the minor's mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; and,

b) Clarifying that removal from the home, or risk of removal from the home, cannot be used as the sole determinant of a child being seriously emotionally disturbed.

2) Requires the MHSOAC to annually report to the Legislature, as specified, the outcomes for those receiving community MH services under an FSP. Requires the report to include such information as persons eligible for FSPs with respect to the services they receive and their experiences with incarceration or criminalization; housing status or homelessness; and hospitalization, emergency room utilization, and crisis services utilization.

3) Requires the report to also include information about those who separate from an FSP, as specified, and to assess the degree to which individuals most in need are accessing services and maintaining participation in an FSP.

4) Requires the MHSOAC to report any barriers to receiving data relevant to completing the required report and to include recommendations to strengthen FSPs, as specified. Requires the MHSOAC to consult with specified MH organizations and subject matter experts. >

Related Legislation:

SB 749 (Glazer and Eggman) requires the MHSOAC, in consultation with state and local mental health authorities, to create a comprehensive tracking program for county spending on mental and behavioral health programs and services, including funding sources, funding utilization, and outcome data at the program, service, and statewide levels. *SB 749 was placed on this Committee's Suspense file on April 19, 2021.*

AB 686 (Arambula) requires the California Health and Human Services Agency (CHHSA) to establish the California Community-Based Behavioral Health Outcomes and Accountability Review (CBBH-OAR) to facilitate a local accountability system that fosters continuous quality improvement in county behavioral health programs and in the collection and dissemination by the agency of best practices in service delivery. Requires the Agency to convene a workgroup to establish a work plan by which the CBBH-OAR is conducted and to consult on various other components of the CBBH-OAR process. *AB 686 is pending in the Assembly Committee on Health.*

Prior legislation. SB 1101 (Pan of 2018) would have required the MHSOAC to establish statewide objectives and metrics, as specified, to bring focus on the state's mental health system and to assist the public in understanding whether progress is being made toward meeting the goals of the MHSA, as specified. SB 1101 would have required the MHSOAC to collect data and monitor the established metrics, and to work with specified stakeholders to monitor counties' progress toward meeting the statewide objectives, as specified. *SB 1101 was held on the Senate Appropriations Committee suspense file.*

Staff Comments: MHSOAC cost details:

There are two paths for this analysis:

1. Using data from the DCR (self-reported status changes on CJ involvement, housing status, hospitalization status).
2. A hybrid approach of linking other state data systems to the FSP client data. OAC is on this path now, with DOJ arrest data already linked for the prior years;

and seeking hospital/ER admissions data. Housing status would still have to be the self-reported.

Tracking statuses after exit from an FSP can only be done through linkages with other data. The housing status would not be available once clients have exited an FSP, unless counties would be required to continue to track outcomes for former FSP clients. So we would need a mechanism for surveying housing status after exit.

Most of this work is within scope of what we are seeking to do already, but it would tie is to specific reporting and analytical responsibilities.
By creating a requirement that we do this work, it creates new mandated workload: receiving and managing the DHCS datasets; acquiring other datasets and linking those to DHCS client records; managing the linked data; analyzing the linked data; developing and maintaining dashboards and annual reports to report on the analyses.

The Commission will request baseline funding for our existing UCSF contracted staff:

- A database manager to support the work of the unit. We estimate 25 percent time devoted to this specific work and the balance to other database management activities.
- A database programmer/analyst to support the work of the unit. Approximately 25 percent time devoted to this specific work and the balance to other database activities.
- A Research Scientist III to lead the analytics. 50 percent time.
- A Research Scientist I to perform routine analyses. 100 percent time.
- A technical writer to support production of written reports, briefs, fact sheets. 50 percent time.
- Support for our data PaaS. Approximately 25 percent of the annual iFish and SAS costs.

Recommended Amendments: MHSOAC recommends amending the bill and to require Department of Justice and OSHPD to transmit data to the Commission.

-- END --

SUSAN TALAMANTES EGGMAN
REPRESENTING SENATE DISTRICT 05

SB 465 – Strengthening Full Service Partnerships

SUMMARY

Current regulations in California require that full service partnerships (FSPs) receive at least half of the funds set aside for Community Services and Supports from the Mental Health Services Act. This bill would require the Mental Health Services Oversight and Accountability Commission (MHSOAC) to report to the Legislature each year on how FSPs are meeting the goal of serving Californians most in need of the intensive, wraparound care that FSPs provide, and how the programs may be improved to prevent the high and increasing prevalence of homelessness, criminalization, and hospitalization for those experiencing severe mental illness. The bill would also expand the eligibility for MHSA-funded services to an increased pool of children who would qualify for and benefit from those services.

BACKGROUND

FSPs are a crucial piece of California's public mental health service system, and receive a significant investment from the Mental Health Services Act (anticipated to be nearly $1 billion this year). Though these programs are designed to focus on Californians of all ages experiencing the most severe mental health challenges, the programs could be strengthened to better prevent homelessness, criminalization, and hospitalization of those experiencing severe mental illness.

In 2019, the Fresno County Department of Behavioral Health requested that the MHSOAC approve a multicounty project to reframe FSPs around an "outcomes-oriented" approach that remains client-centered. Additionally, LA County has started work on a project with Third Sector "to facilitate an agency-wide shift to an outcomes orientation, beginning with the transformation of approximately $102M in recurring intensive mental health services contracts."

These projects indicate that there is work being done at the local level in recognition that FSPs can be improved and strengthened to achieve more robust outcomes and be more fully accountable.

The sad reality of mentally ill individuals on the streets in many communities tell us that we must make better use of the resources allotted to these problems. Estimates by the Treatment Advocacy Center are that as many as one-third of California's population experiencing homelessness are also living with a serious mental illness. That could mean, even conservatively, tens of thousands of those living houseless in the community are also experiencing a – likely untreated, or undertreated – mental illness. Recent reporting by CalMatters uses state data indicating up to one-third of incarcerated Californians live with documented mental illness (pre pandemic).

The historical arc of people who become homelessness or incarcerated provides ample evidence of missed opportunities to intervene and provide effective treatment thereby reducing these outcomes. Early intervention is critical and must start at a much earlier age. This bill expands the eligibility criteria for children for MHSA funded services in order to prevent more severe outcomes later in life.

THIS BILL

SB 465 would amend the Mental Health Services Act to broaden the group of children eligible for MHSA-funded services. It would also require the MHSOAC to report to the Legislature the outcomes from FSPs; how they are serving those who are hospitalized, criminalized, and experiencing homelessness; and make recommendations on how FSPs may be improved to better serve these populations.

SUPPORT

Psychiatric Physicians Alliance of California (Sponsor)

FOR MORE INFORMATION

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Logan Hess
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916.651.4005

Mental Health Services
Oversight & Accountability Commission

Revised May 17, 2021

I. Commission Positions on 2021 Legislation

Commission Sponsored Legislation

➢ Assembly Bill 573, Assemblywoman Carrillo: Youth Mental Health Boards (Amended March 18, 2021)

Summary: AB 573 establishes the California Youth Mental Health Board (state board) within the California Health and Human Services Agency to advise the Governor and Legislature on the challenges facing youth with mental health needs and determine opportunities for improvement. The state board would be comprised of 15 members who are between 15 and 23 years of age, and at least half of whom are youth mental health consumers who are receiving, or have received, mental health services, or siblings or immediate family members of mental health consumers. The bill would specify the powers and duties of the state board, including reviewing program performance in the delivery of mental health and substance use disorder services for youth.

This bill will also require each community mental health service to establish a local youth mental health board (board) consisting of eight or more members, as determined by the governing body, and appointed by the governing body.

- **Position:** The Commission voted to sponsor this bill at its February 17, 2021 meeting.
- **Location:** Assembly Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

Mental Health Services
Oversight & Accountability Commission

Revised May 17, 2021

Commission Co-Sponsored Legislation

- **Senate Bill 224, Senator Portantino: Pupil Instruction – Mental Health Education (Amended March 17, 2021)**

Summary: SB 224 requires each school district to ensure that all pupils in grades 1 to 12, inclusive, receive medically accurate, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school. The bill would require that instruction to include, among other things, reasonably designed instruction on the overarching themes and core principles of mental health. The bill would require that instruction and related materials to be appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners.

- **Position:** The Commission voted to co-sponsor this bill at its February 17, 2021 meeting.
- **Location:** Senate Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

Mental Health Services
Oversight & Accountability Commission

Revised May 17, 2021

Commission Supported Legislation

- **Assembly Bill 638, Assemblymember Quirk-Silva: Mental Health and Substance Use Disorders (Amended March 26, 2021)**

  Summary: AB 638 authorizes prevention and early intervention strategies that address mental health needs, substance use or misuse needs, or needs relating to co-occurring mental health and substance use services under the Mental Health Services Act.

  Last year, the Commission supported Assembly Bill 2265, authored by Assemblymember Quirk-Silva, that clarified the Mental Health Services Act funds can include substance use disorder treatment for co-occurring mental health and substance use disorders, for individuals who are eligible to receive mental health services. The Governor signed into law AB 2265, Ch. 144, Statutes of 2020.

  AB 638 amends the MHSA by including a provision to authorize prevention and early intervention services for prevention and early intervention strategies that address mental health needs, substance use or abuse needs, or needs relating to cooccurring mental health and substance use services.

  - **Position:** The Commission voted to support this bill at its March 25, 2021 meeting.
  - **Location:** Senate Health Committee – No scheduled hearing.

- **Senate Bill 14, Senator Portantino: Pupil Health – School Employee and Pupil Training – Excused Absences – Youth (Amended March 18, 2021)**

  Summary: Current law, requires a pupil to be excused from school for specified types of absences, including, among others, if the absence was due to the pupil's illness. AB 14 would include as another type of required excused absence an absence that is for the benefit of the behavioral health of the pupil.

  - **Position:** The Commission voted to sponsor this bill at its February 17, 2021 meeting.
  - **Location:** Senate Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

- **Senate Bill 749, Senator Glazer: Mental Health Program Oversight and County Reporting (Introduced February 19, 2021)**

  Summary: SB 749 will require the Commission, in consultation with state and local mental health authorities, to create a comprehensive tracking program for county spending on mental and behavioral health programs and services. This bill will require counties to report funding source, funding utilization, and outcome data at the program, service, and statewide levels. The Commission will be required to submit a report of the to the Governor and the Legislature each year.

  - **Position:** The Commission voted to support this bill at its March 25, 2021 meeting.
  - **Location:** Senate Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

II. MHSOAC 2021 Legislative Tracking

Suicide Prevention

- **Assembly Bill 234, Assemblymember Ramos: Office of Suicide Prevention Clean-Up (Introduced January 12, 2021)**

  Summary: AB 234 is a clean-up bill for 2020's AB 2112 (Ramos), which created the framework for a statewide Office of Suicide Prevention. The Commission sponsored AB 2112 last year and the recommendations in the bill are consistent with our *Stiving for Zero*, report. This bill removes the requirement that the Department of Public Health fund the Office of Suicide Prevention using existing resources, opening the door for the development of a statewide suicide prevention strategy.

  - **Location:** Assembly Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

Mental Health Services
Oversight & Accountability Commission

Revised May 17, 2021

Mental Health

- **Senate Bill 465, Senator Eggman: Mental Health (Amended April 26, 2021)**

Summary: SB 465 expands the eligibility criteria for children for MHSA-funded services in order to prevent more severe outcomes later in life. It would also require the Commission to report to the Legislature the outcomes from Full Service Partnerships (FSPs); how they are serving those who are hospitalized, criminalized, and experiencing homelessness; and make recommendations on how FSPs may be improved to better serve these populations.

- **Location:** Senate Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

Schools and Mental Health

- **Assembly Bill 586, Assemblymember O'Donnell: School Health Demonstration Projects: Building and Sustaining K-12 School-Based Services (Amended April 19, 2021)**

Summary: AB 586 establishes, within the State Department of Education, the School Health Demonstration Project, a pilot project, to be administered by the department, in consultation with the State Department of Health Care Services, to expand comprehensive health and mental health services to public school pupils by providing training and support services to selected local educational agencies to secure ongoing Medi-Cal funding for those health and mental health services.

- **Location:** Assembly Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

- **Senate Bill 508, Senator Stern: Student Mental Health Services (Amended April 14, 2021)**

Summary: SB 508 will require health plans to provide mental health services to students. It would also make children's mental health services more accessible by expanding the network of school-based mental health practitioners and use of telehealth. This bill:

- Ensures health plans are meeting the requirement to provide mental health services to students who are referred by the school.
- Makes it easier to access children's mental health experts by permanently adopting telehealth options established during the pandemic.

- Ensures that commercial health plans are meeting mental health parity standards by requiring them to collaborate with local education agencies.

❖ **Location:** Senate Health Committee – May be acted upon January 2022.

➢ **Senate Bill 525, Senator Grove: Mental Health Effects of School Closures (Amended March 22, 2021)**

Summary: SB 525 requires the State Department of Public Health, in consultation with the State Department of Education, to establish a policy no later than 6 months after the effective date of the bill, to address the mental health effects of school closures on pupils in years when a state or local emergency declaration results in school closures. The bill would require local educational agencies to adopt the policy subject to an appropriation in the annual Budget Act for that purpose.

❖ **Location:** Senate Appropriations Committee – Hearing on May 20, 2021, upon adjournment of session.

Research and Evaluation

➢ **Assembly Bill 686, Arambula: California Community-Based Behavioral Health Outcomes and Accountability Review (Introduced February 16, 2021)**

Summary: AB 686 requires the California Health and Human Services Agency to establish, by July 1, 2022, the California Community-Based Behavioral Health Outcomes and Accountability Review to facilitate a local accountability system that fosters continuous quality improvement in county behavioral health programs and in the collection and dissemination by the agency of best practices in service delivery. The bill would require the agency to convene a workgroup, by October 1, 2022, composed of representatives, as follows:

- County behavioral health agencies
- Legislative staff
- Behavioral health provider organizations
- Interested behavioral health advocacy and academic research organizations
- Current and former county behavioral health services recipients and their family members
- Organizations that represent county behavioral health agencies and county boards of supervisors

- California External Quality Review Organizations
- State Department of Health Care Services
- State Department of Social Services
- State Department of Public Health
- California Behavioral Health Planning Council
- Mental Health Services Oversight and Accountability Commission

The purpose of the workgroup is to develop an updated methodology, that can measure and evaluate behavioral health services.

❖ **Location:** Assembly Health Committee – May be acted upon January 2022

MISCELLANEOUS ENCLOSURES

May 27, 2021 Commission Meeting

Enclosures (7):
(1) Staff Analysis: Sonoma County Nuestra Cultura Social Innovation Lab
(2) Innovation Plan: Sonoma County Nuestra Cultura Social Innovation Lab
(3) April 22, 2021 Motions Summary
(4) Evaluation Dashboard
(5) Innovation Dashboard
(6) Department of Health Care Services Revenue and Expenditure Reports Status Update
(7) Calendar of Tentative Agenda Items

Handouts: None

STAFF ANALYSIS— Sonoma County

Innovation (INN) Project Name:	**Nuestra Cultura Cura Social Innovation Lab**
Total INN Funding Requested:	**$736,584**
Duration of INN Project:	**Three Years**
MHSOAC consideration of INN Project:	**April 2021**

Review History:

Approved by the County Board of Supervisors:	February 23, 2021
Mental Health Board Hearing:	December 5, 2020
Public Comment Period:	November 13, 2020 to December 14, 2020
County submitted INN Project:	February 3, 2021
Date Project Shared with Stakeholders:	April 14, 2020 & November 18, 2020 & February 10, 2021

Project Introduction:

Sonoma County is requesting up to $736,584 of Innovation spending authority to increase knowledge and access to unserved or underserved groups (particularly the County's large Latinx population) **and** to increase quality of mental health services, including better outcomes.

The program will use a social innovation model to develop a greater understanding of the unique challenges faced by the Latinx community in Sonoma County. This will be accomplished through the development of a diverse team of 25 Latinx stakeholders from different sectors of the community, which will eventually prototype new culturally relevant services and interventions. These interventions will be developed for the Latinx community by the Latinx community, and will aim to use art, wellness, spirituality, and social connections specific to this community to reduce stigma in and increase the quality of behavioral health services in the County.

What is the Problem?

In Sonoma County, disparities in mental health care for Latinos are severe, persistent, and well documented, yet there are few programs available that address the significant impact that stigma and lack of knowledge have on accessing mental health supports. The

County identifies three components of the problem (pages 3-5 of the plan): Latinx community members are hesitant to access clinical mental health services aimed at early intervention services, existing clinical mental health services do not match the Latinx community's desires and needs for support, and there are no effective culturally relevant mental health strategies that were developed by the Latinx community itself. Members of the Latinx community tend to seek out coping and healing mechanisms through their community and cultural opportunities, as opposed to clinical mental health services. This can be due to both (1) cultural stigma surrounding behavioral health in the Latinx community and (2) language barriers in the services provided though the County's behavioral health system.

How this Innovation project addresses this problem:

To address the mental health disparities facing the Latinx community, the County will contract out to the local organization, On the Move (OTM) and build off their years of research and development of the La Plaza cultural arts model (see page 4 of the project plan). The project will employ the La Plaza model to create culturally rich, non-clinical mental health services for the Latinx population of Sonoma County. This will be accomplished through a social innovation lab, led by Latinx community members who will work to develop and implement a comprehensive service delivery strategy aimed at decreasing stigma and increasing access to culturally competent mental health services.

Moreover, the project will bring together five local Latinx organizations from the community, each specializing in different components of Latinx culture and/or mental health: On The Move*, Humanidad* Therapy & Education Services, Latino Service Providers, *Raizes* Collective and North Bay Organizing Project (for more information on these organizations see page 7 of the county plan). Two of these organizations (Latino Service Provider and Humanidad) are already receiving CRDP funds to implement projects targeting the same population as Nuestra Cultura Cura, but differ in engagement strategies and service delivery systems. Though the projects have similar goals in mind, they are each different parts of a whole effort to achieve improved outcomes for the Latinx community.

The social lab model enables participants to collaboratively tackle complex issues in ways that promote innovative and profound change. This project, in accordance with the social lab model, will be implemented through four phases. The first phase (months 1-6) will gather the above five organizations into a retreat session where the specific intent of the project will be clearly articulated in the form of a call to action, therefore making it accessible to future invited participants of the lab. This "project pitch" will be sent to a broad spectrum of members of the Latinx community, identified through the broad networks established by the project's five partner organizations. Then, finally 20 participants will be chosen, upon which they will receive compensation for their participation in the lab (see page 8 of the plan).

The second phase (months 6-9) will establish a strategic direction of the lab. In this phase, a facilitator will be hired, and lab participants will be able to receive any additional training and opportunities to share experiences with their peers.

The third phase (months 10-34) is when the innovation team along with the project partners will participate in workshops where they will build knowledge of the mental health system, brainstorm potential innovations, and prototype solutions. The Innovation Lab Team will implement at least three of these prototyped innovative solutions, which will engage at least 500 members of the Latinx community. Each innovative solution will include an evaluation plan. The final phase (months 34-36) will be used to create an evaluation report to document and share the lessons learned from the project.

Furthermore, Nuestra Cultura Cura is aligned with the California Reducing Disparities Project (CRDP). This project, though distinct in its implementation, will focus on and build upon many of the same strategies as CRDP, such as community-defined evidence gathering, cultural and linguistic responses to mental health disparities, and population-specific early intervention/prevention programs. The County aims to empower the Latinx community to take a more involved role in shaping the services, or lack thereof, that affect them.

Community Planning Process (pages 17-22 of the project plan)

Local Level

Sonoma County receives guidance from a MHSA Steering Committee, Stakeholder Committee, county staff and contractors, and other interested parties, which all provide input to the County in its MHSA planning and implementation activities.

In the case of this project, On the Move and the other four project partner organizations were all involved in the community planning process, and ultimately, in the creation of the plan. Based on feedback collected by On the Move during three community town hall events, over 400 Latino community members discussed the significant impact that stigma and lack of knowledge have on accessing mental health supports, and that the community wanted non-clinical mental health services.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on both April 14, 2020 and November 18, 2020 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared with stakeholders on February 10, 2021.

At the date of this writing, no comments were received in response to Commission sharing the plan with stakeholder contractors and the listserv.

Learning Objectives and Evaluation:

The County expects to serve a total of 500 members of the Latinx community throughout the duration of the project.

The County identified the following two learning goals:

1. What more can we understand about the unique challenges that inhibit Latinx community members from accessing mental health services in Sonoma County?
2. How might using culturally specific interventions and language improve the quality of mental health services for the Latinx community?

The County has also identified four desired outcomes to increase access to and increase quality of mental health services in both the short-term and the long-term:

Increase access

- Short-term: Lab members identify core problems, symptoms and contributing factors that inhibit Latinx community members from accessing mental health services in Sonoma County
- Long-term: Latinx adults and youth are more willing and able to access mental health that address challenges and barriers

Increase quality

- Short-term: Latinx adults and youth participate in mental health interventions that are culturally and linguistically appropriate
- Long-term: Latinx adults and youth experience strengthened cultural protective factors and reduced depression and anxiety

Lab team members will be provided opportunities to provide ongoing input on the processes and effectiveness of the lab via participatory evaluation. This participatory evaluation covers everything from feedback on the makeup of the team to evaluation of team dynamics. Eventually, the team, in collaboration with the team facilitator and OTM's expert evaluation consultant, will create evaluation methods measuring Latinx community members' increased willingness and ability to access mental health services. **These will depend on the prototype solutions created by the team; therefore, adapted evaluation methods will be determined to measure the effectiveness in these solutions to reach the desired outcomes. These measures will include baseline data, demographics, and more, all with the goal of creating culturally appropriate data collection tools.**

The Budget (pages 27-28 of the project plan)

Innovation Funds	$278,285	$262,082	$196,217	$ 736,584
3 Year Budget	Year-1	Year-2	Year-3	**TOTAL**
Personnel	$ 112,845	$ 96,642	$ 58,137	$ 267,624
Operating Costs	$ 3,360	$ 3,360	$ 3,360	$ 10,080
Evaluation	$ 38,080	$ 38,080	$ 34,720	$ 110,880
Other Expenditures	$ 124,000	$ 124,000	$ 100,000	$ 348,000
TOTAL:	$ 278,285	$ 262,082	$ 196,217	**$ 736,584**

The County is requesting authorization to spend up to 736,584 in MHSA Innovation funding for this project over a period of three years.

- Personnel costs total $267,624 (36% of total budget) to hire a Project Director (0.5 FTE), Project Coordinator (1.0 FTE) and an Outreach Coordinator (.25 FTE). There are also indirect personnel costs at 12% to cover overhead expenditures (administrative staff, insurance, etc.).
- Operating costs total $10,080 (1% of total budget) which include $1,000 for travel annually, $1,500 for supplies, and indirect costs at 12% which cover cost for rent, utilities, and communications.
- Evaluation costs total $110,880 (15% of total budget) include costs of the project Facilitator and the Evaluation Consultant.
- $348,000 (47% of total budget) will be allocated to other expenditures that include stipends for Lab Team members and partner agency support contracts.

Sonoma County has $822,000 in MHSA Innovation dollars that are subject to reversion on June 30, 2021. Sonoma County is submitting four Innovation proposals simultaneously, including this proposal for Nuestra Cultura Cura, to the MHSOAC.

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

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Nuestra Cultura Cura Social Innovation Lab

Sonoma County Innovation
2021-2024 Plan Proposal

Nuestra Cultura Cura Social Innovation Lab

SECTION 1: Innovations Regulations Requirement Categories

General Requirement

	Introduces a new practice or approach to the overall mental health system, including prevention and early intervention
X	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 non-mental health context or setting to the mental health system

Primary Purpose

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

SECTION 2: Project Overview

Primary Problem

In Sonoma County, the Latinx/Hispanic population has grown by almost 230 percent within the last 25 years.[1] In 2018, 87% of residents identified as White with 27% identifying as Hispanic or Latinx, the County's largest minority population.[2] According to the most recent Sonoma County Capacity Assessment (FY2016-19), this underserved group makes up almost 30% of the County's general population and over 40% of Sonoma's Medi-Cal population, while only 23% of DHS-BHD consumers were of Hispanic ethnicity.

In Sonoma County, **disparities in mental health care for Latinos are severe, persistent, and well documented**. Although it is presumed that Latinos in Sonoma County are able to access mental health services through a number of clinical mental health service providers, ***the Latino mental health penetration rate in Sonoma County remains below 2%***, which is lower than comparative counties and one of the lowest penetration rates in the state of California (3.78%).[3] Furthermore, the recent Capacity Assessment conducted for Sonoma County reports that "**Both consumers and providers noted difficulties accessing or supplying services in Spanish."** While about one fifth of consumers identified as Hispanic, very few services were offered in Spanish. Many reported a need for a greater quantity and variety of high-quality services in Spanish that accept consumers regardless of citizenship status. Stakeholders noted that the lack of culturally competent and bilingual staff resulted in the Hispanic community accessing a

[1] Sonoma County Economic Development Board, *Hispanic Demographic Trends, 2017*
[2] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[3] Behavioral Health Concepts, Inc. Sonoma County MHP CalEQRO Report. Fiscal Year 2018-19.

lower level of care than others or being deterred from accessing care altogether. For example, when monolingual Spanish-speakers tried to access counseling services oftentimes they were only offered education or wellness opportunities due to the lack of in-county bilingual clinicians.

Service limitations were particularly true for undocumented residents, who had limited access to facilities that were often over capacity and inconsistent in quality. Limited services in Spanish and culturally relative to Sonoma's Latinx/Hispanic population may have led to increased use of higher-level services. During fiscal year 2018-2019, a high proportion of Latinx consumers went to the CSU, though slightly less than consumers overall.

Over 25% of Sonoma households speak a language other than English at home, of which about 19% speak Spanish – the County's only threshold language.[4] About 11% of residents speak English less than "very well," suggesting possible linguistic isolation for this population.[5] Additionally, there are an estimated 38,500 undocumented residents in the County.[6] Individuals who are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services. If services are limited by language, it can reduce access as well as the quality of services available – particularly for individuals with lower levels of income.

Based on feedback collected by OTM during three "community town hall events", over 400 Latino community members discussed the significant impact that stigma and lack of knowledge have on accessing mental health supports, primarily prevention and early intervention services. Many people in attendance at these town hall meetings reported that even if there were sufficient affordable clinical mental health services available in Sonoma County, they would not be willing to access them due to fears related to safety, fear of judgement and/or a fear of not being able to understand the service provider. Instead, these Latinos indicated an interest in non-clinical mental health strategies that build cultural protective factors and improve mental health through art, wellness, spirituality, and social connections. The strong cultural identity of the Latinx community combined with the complexities of the current socio-political-economic environment reinforces the fact that the current traditional western mental health system of care is not adequate to meet the needs of the larger Latinx community.

1) **Latinx community members are hesitant to access clinical mental health services aimed at early intervention services:**

   First, as a culture, Latinos do not talk about mental health, which is shrouded in a negative stigma. Many Latinos associate mental illness with being "crazy"; stigma often manifests itself in the form of shame and fear of being judged. Many are reluctant to recognize their problems as psychiatric and do not want treatment that focuses on psychiatric symptoms. Only 20% of Latinos with symptoms of a psychological disorder talk to a doctor about their concerns, and only 10% contact a mental health specialist.[7]

   Second, even if they wanted to talk about mental health, Latinos do not often find someone who would listen. The current shortage of mental health professionals in Sonoma County and across California[8] is more severe for Latinos and other minorities, who face barriers of

[4] U.S. Census Bureau, American Fact Finder. (2018). *Occupied housing units, 2013-2017 American Community Survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_B25106&prodType=table

[5] U.S. Census Bureau. (2018). *Selected social characteristics on the United States, California.* Retrieved from https://data.census.gov/cedsci/table?d=ACS%205-Year%20Estimates%20Data%20Profiles&table=DP02&tid=ACSDP5Y2017.DP02&y=2017&g=0400000US06_0500000US06097&lastDisplayedRow=146

[6] Hayes, J. & Hill, L. (2017). *Undocumented immigrants in California.* Retrieved from https://www.ppic.org/content/pubs/jtf/JTF_UndocumentedImmigrantsJTF.pdf

[7] http://publications.unidosus.org/bitstream/handle/123456789/1381/file_WP_Latino_Mental_Health_FNL.pdf

[8] https://data.hrsa.gov/topics/health-workforce/shortage-areas

language and culture that can make it hard to seek and get help. These language issues also prevent many Latinos from being able to express themselves or discuss their symptoms with their healthcare providers.

Third, even if Latinos are willing to talk about mental health and can find a bilingual, bicultural mental health professional, they are often not able to afford the help they need. A recent Urban Institute report showed that about one in seven (13.7%) adults in immigrant families reported that they or a family member did not participate in—meaning they did not apply for or dropped out of – a non-cash benefit program in 2018 out of fear of risking future immigration options. Among adults in low-income families earning less than 200% of the federal poverty level, this rate was one in five (20.7%).[9] Regardless of immigration status, Latinos constitute the largest group of uninsured in the U.S.— more than half of California's remaining 2.9 million uninsured are Latino.[10] Without adequate health insurance, Latino community members, especially monolingual Spanish speakers, are not able to afford the limited services available to them.

2) Existing clinical mental health services do not match the Latinx community's desires and needs for support.

On The Move (OTM) has actively engaged Sonoma County Latinos in identifying their needs and desired supports over the last three years through the planning and formation of the *La Plaza Project.* OTM initiated its first cohort of Latino community leaders in 2016, which took on the task of defining key issues surrounding mental health in the Latinx community. These Latino leaders conducted key informant interviews, in-depth research to better understand to what extent mental health services are available but not accessed by the Latino community, how weak linkages between community and County services impact access, and the scope of the shortage of bilingual and bicultural mental health practitioners in the region. Their research led them to conduct an extensive storytelling project with 55 Latino community members, through which they learned that ***while stigma and a lack of bilingual services discourage many Latinos from seeking out clinical mental health services, many Latinos desire to find healing through community and cultural expressions and not through the clinical mental health system.***

Current MHSA funded Latinx focused projects in Sonoma County:
In fiscal years 2018-2021 Sonoma County funded one MHSA Prevention and Early Intervention (PEI) program focused on the Latinx population. There were no other MHSA funded programs focused on the Latinx population in fiscal years 2018-2021. There were WET deliverables for LSP in the PEI scope of work until 2018. In 2018 the PEI funding for LSP was reduced from $160,000 to $85,000 due to budget cuts in Sonoma County's Department of Health Services.

The MHSA PEI funded Prevention program is operated by Latino Service Providers (LSP). The mission of LSP is to serve and strengthen Latinx families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life.

[9] https://www.urban.org/urban-wire/public-charge-rule-looming-one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018

[10] https://www.chcf.org/publication/2017-edition-californias-uninsured-coverage-grows-millions-without/

To reduce disparities, the specific focus of LSP's PEI program is to utilize a networking model among community providers to exchange information about activities and resources that will promote economic stability and educational success; increase access to healthcare, mental health, housing, and legal services and resources; reduce the stigma associated with behavioral/mental health issues; and to address other areas of interest for families throughout Sonoma County.

In addition to the singular Latinx focused PEI program, Sonoma County has two Latinx California Reducing Disparities Projects (CRDP): Humanidad's *Convivencia* project and Latino Service Providers' *Testimonios* project. The *Nuestra Cultura Cura* Social Innovations Lab is directly aligned, though distinct, from Sonoma County's two Latinx CRDPs. *Nuestra Cultura Cura* project will rely on community defined evidence practices, which are innovative and culturally-rooted traditions designed by the communities they serve, and will ensure mental health equity by providing culturally and linguistically responsive prevention and early intervention services.

Even with these efforts, the disparities in mental health care for Latinos continue to be severe and persistent.

3) Effective, culturally relevant mental health strategies must be developed by the Latinx community itself

These initial findings about mismatch in services and needs have been echoed repeatedly in OTM's community-led research. In April 2018, Latino community leaders led a town hall process for over 200 Latino students, parents, seniors and service providers to create a visual representation of how Latinos want to improve their mental health: through the creation of programs where community members can rebuild cultural protective factors and improve mental health through art, wellness, spirituality, and social connections.

Health and social problems occur in the context of family, community and culture. Outside of OTM's three-year, community-led research process, Sonoma County has done little to engage Latinos in creating mental health strategies that acknowledge and integrate cultural values and family preferences. It is imperative that Latinos are given the opportunity to define and solve problems most relevant to them and to generate new cultural norms that mirror the values and aspirations that community members have for their children. Because lasting culture change requires the community to embrace new ways of thinking and behaving, change must be centered on the community. Diverse community members—those most affected by adversity; those committed to improving the lives of children and families; and those ready and willing to offer resources that will support small, iterative layers of change—must engage in hopeful, creative dialogue about how they want things to change, and then begin and sustain the process with small changes that will build into larger transformations.[11]

Proposed Project

Social innovation is about profoundly changing or transforming a system rather than adapting or improving it. Real change that helps solve complex social challenges, like building an effective, affordable mental health system, can only be achieved when three elements of a system are

[11] Porter, L., Martine, K., Anda R. (2016) *Self Healing Communities: A Transformational Process Model for Improving Intergenerational Health.* Robert Wood Johnson Foundation.

being innovated. First, when present solutions do not work, we need to develop new solutions. As it is impossible to predict what works, we need to experiment. Second, we need to innovate the way the system behaves. It can require changing public policy, but also organizations changing their strategies. It is about creating the conditions for new solutions to become accepted and replace the old ways. Third, we need to build the capacity of the people and organizations involved. Simply saying they need to change will not work. We need to build a movement, starting with the innovators that pioneer new solutions and also engage the early adopters, who see the need to innovate but require some guidance and a safety net.[12]

Social Innovation Labs (also called design labs and change labs) are platforms for addressing complex social challenges using learning, experimentation, innovation and change. Social Innovation Labs provide a structured process for approaching messy and complex challenges and a safe and creative environment to experiment and prototype radical innovations. They also enable deep collaboration among multi-disciplinary teams and diverse stakeholders, and take a consumer-centered approach as opposed to institution- or organization-centered approaches.

The ***Nuestra Cultura Cura*** **Social Innovations Lab** will:

- Draw from different sectors of the community to create a diverse team of 25 Latinx stakeholders, including 5 founding members from partner organizations and 20 community members.
- Build deeper understanding of the root causes of the unique mental health challenges faced by the Latinx community in Sonoma County.
- Prototype experimental, culturally relevant interventions based on art, wellness, spirituality, and social connections that will reduce stigma around mental health among Latinos and increase cultural protective factors that lead to mental health.

The *Nuestra Cultura Cura* Social Innovations Lab will build on OTM's three years of community-led research and the resultant *La Plaza* framework, a community-developed cultural arts model that promotes and enhances the health and well-being of the Latinx community in Sonoma County. The *Nuestra Cultura Cura* Social Innovations Lab will employ the *La Plaza* model to create culturally-rich, non-clinical mental health services for the Latinx population of Sonoma County while working to develop and implement a comprehensive service delivery strategy aimed at decreasing stigma and increasing access to cultural protective factor-promoting, appropriate mental health services.

The Social Innovation Lab will be led by Sonoma County Latinx community members with lived mental health experiences and will authentically engage the community in order to collect and analyze needs data, and design and implement prototype culturally relevant solutions. **OTM's *Nuestra Cultura Cura* Social Innovation Lab addresses the challenges of two of Sonoma County's Innovation Funding primary purposes:**

- **Increase access to unserved or underserved groups**: The *Nuestra Cultura Cura* Social Innovations Lab will increase access to culturally relevant, non-clinical mental health services for at least 500 Latino community members who are underserved, unserved or inappropriately served. At least 500 Latinx community members will participate in Social Innovations Lab prototype mental health strategies.
- **Increase quality of mental health services, including better outcomes:** The Social Innovations Lab will replace inappropriate mental health services with culturally relevant mental health strategies that will reduce depression and anxiety and promote cultural

[12] Westley, F., Laban, S. (2015) Social Innovation Lab Guide. Rockefeller Foundation, https://www.rockefellerfoundation.org/report/social-innovation-lab-guide/

protective factors among Latinos. The Social Innovation Lab will create culturally-relevant evaluation tools to collect data around individual participants' mental health symptoms and their growth in cultural protective factors.

The *Nuestra Cultura Cura* Social Innovations Lab is directly aligned, though programmatically distinct, from Sonoma County's two Latinx California Reducing Disparities Projects (CRDP). Like Humanidad's *Convivencia* project and Latino Service Providers' *Testimonios* project, the *Nuestra Cultura Cura* project will rely on community defined evidence practices, which are innovative and culturally-rooted traditions designed by the communities they serve, and will ensure mental health equity by providing culturally and linguistically responsive prevention and early intervention services. This Innovations Project reflects the core strategies of the statewide CRDP, including increasing access to mental health services for unserved, underserved and inappropriately served populations; improving the quality of mental health services for unserved, underserved and inappropriately served populations; building on community strengths to increase the capacity of and empower unserved, underserved and inappropriately served populations; and developing, funding and demonstrating the effectiveness of population-specific and tailored programs.

The *Nuestra Cultura Cura* Social Innovations Lab will support a unique collaboration of five key Latino-led mental health and cultural arts organizations, including **On The Move*, Humanidad* Therapy & Education Services**, Latino Service Providers, *Raizes* Collective and North Bay Organizing Project**. Each of these partners brings a specific expertise in mental health, community organization and/or cultural arts and connection to the Latinx community in Sonoma County.

On The Move partners with communities and mobilizes emerging leaders to take action in pursuit of social equity. OTM builds youth-led initiatives that explore approaches to closing the achievement gap, promote wellness and inclusion, reduce social and economic barriers, support youth in their transition into adult independence, increase family self-sufficiency, and develop emerging leadership in the public sector. Over the last three years, OTM has led a community-research and leadership development program for Latinx community leaders that resulted in the *La Plaza* community mental health model. OTM will be the lead agency for the administration of this Innovation Project.

Humanidad Therapy & Education Services is a multicultural community mental health agency offering low-fee clinical services. Humanidad primarily serves low-income Latinx community members in Santa Rosa. With the support of the California Reducing Disparities Project, Humanidad is implementing the *Convivencias* model, a space of *familismo* (family), *respeto* (respect), and *personalismo* (relationships), where community members feel safe to engage in storytelling and share life experiences while learning from others. The strategies being integrated include culturally relevant community events (*Community Convivencias)* and group counseling *(Group Convivencias),* both with the main purpose to increase a sense of belonging, self-esteem, and a quality of life.

Latino Service Providers (LSP) is a member organization comprised of over 1,400 members who work together to educate and network in support of the Latino community, to improve access to healthcare, mental health services, education, legal support and other social services available in our area. With the support of the California Reducing Disparities Project, LSP is implementing the *Testimonios* project, a five-year initiative that trains students to become mental health Youth Promotores skilled at collecting and disseminating information about mental and behavioral health issues affecting the local Latino community

Raizes Collective is an arts organization based in Santa Rosa, established to empower and mobilize community through the arts, culture and environmental education. The Collective offers

artists and teachers of color the resources of space, programming, events, shows and activities to affect social and political change through art and community building.

North Bay Organizing Project (NBOP) is a grassroots, multi-racial, and multi-issue organization comprised of over twenty-two faith, environmental, labor, student and community-based organizations in Sonoma County. NBOP is working to unite working class and minority communities to build leadership and grassroots power for social, economic, racial and environmental justice.

The purpose of this collaboration is to engage community organizations in a transformative process of adopting new solutions to improving mental health, evaluating effectiveness, and potentially enhancing a mental health system that does not serve the Latinx community very well. Each organization collaborating on this Innovations project will receive a Partner Agency Support Contract (laid out in the proposed project), supporting them to align their existing services to the project and test out the innovative strategies identified by the Lab team.

Implementation of project and workplan

Drawing from the framework developed by Social Lab expert and author Zaid Hassan, the *Nuestra Cultura Cura* Social Innovations Lab will move through four distinct phases:

Phase 1: Form Social Innovation Lab Team (Months 1-6)

During the first phase, OTM will complete four key milestones that will lay the foundation of the Social Innovations Lab Team:

1. **Clarify Intention**: Using the shared framework of OTM's *La Plaza* model, OTM will convene project partners from Humanidad, Raizes Collective, Latino Service Providers and North Bay Organizing Project in a retreat session to clarify the specific intentions around adopting new practices that reduce stigma and increase cultural protective factors that lead to mental health among Latinos. The clearly articulated intention statements will form the basis of "call to action" needed to recruit Lab Team participants.
2. **Broadcast an Invitation**: OTM will create a project pitch and invitation to participate based on the partners' intentions. The purpose of this "pitch" will be to find Latinx people from a variety of backgrounds, including those with lived mental health experiences, who share our intention to create new solutions that reduce mental health stigma and increase cultural protective factors among Latinos.
3. **Work Networks**: Project partners will use their own networks and the *La Plaza* network to invite Latinx community members to participate in the Social Innovation Lab through emails, one-on-one conversations and group presentations to explain what they are doing, why the Social Innovation Lab is needed, and what resources, connections and skills are needed. Project partners will use this networking process to find those highly connected community members who are needed to deeply understand root causes of stigma and inaccessibility and who can lend unique perspectives to potential solutions.
4. **Recruit Willing People**: Founding Lab members representing On The Move, Humanidad, Raizes Collective, Latino Service Providers and North Bay Organizing Project will recruit 20 Latinx individuals who offer different perspectives, backgrounds and expertise to the project and who share a common interest in the projects' intentions. These intergenerational individuals will represent people with lived mental health experiences, public and non-profit sectors, faith communities, academics and researchers, artists and cultural practitioners. Interested participants will be asked to commit to the full length (28 months) of the project and agree to actively participate in the Lab process. A small stipend ($2,400) will be offered to these individuals.

Phase 2: Design the Social Innovation Lab Iterative Design Process (Months 6-9)

With the membership of the Social Innovation Lab established, the Team will determine its strategic directions and develop an iterative design and working process for the prototype phase. During Phase 2, the Team will accomplish three key milestones:

1. **Set Strategic Direction**: OTM will facilitate a process to allow the Team to self-determine the Innovation Lab's strategic direction for transforming mental health solutions for Latinos, which will set the Team's view of the future, communicate challenges to be overcome and empower the Team to stretch, learn and grow.
2. **Invite a Facilitator**: With a clear strategic direction, the Lab Team will seek out and hire a facilitator whose role will be to support the group and deal with the *how* of the journey, issues such as leadership, decision making, conflict resolution, and clarifying purpose. While the Team will determine their own selection criteria for their facilitator, OTM intends that this expert will be Latinx, Spanish-speaking and skilled in design thinking, group dynamics, community participatory planning and research and community health.
3. **Clarify the Iterative Design Process**: With the support of the facilitator, the Lab Team will set its process for innovation and problem solving, research and learning, capacity building and governance. Inherent in this process will be determining needs for additional training and opportunities for lab members to share experiences and expertise with their peers. All Lab members will work together to create shared agreements and commitments, a meeting and work schedule and an accountability structure to ensure that Lab members are able to successfully complete their commitment to their Team.

Phase 3: Prototype Solutions - Trial, Error, Observation, Reflection (Months 10-34)

A Social Innovation Lab is about strategically bringing the right people together to engage in:

- Sense-making, (understanding what is happening and why) which in turn infuses a situation with meaning and the motivation to act;
- Identifying the new emerging patterns, programs, initiatives, ideas that could transform the problem domain;
- Identifying the opportunities to shape or influence new partnerships, resource flows and protocols that could support such transformation.

Social Innovation Labs generally consist of three types of workshops:[13]

Building Understanding of the System: The first workshops are designed to engage participants in broad and deep understanding of the system in which they are concerned, opening up new possibilities for interpretation. In these early stages we will draw heavily on some of the whole system thinking, to create the experience of unfreezing problem perspectives and surfacing diversity.

Exploring Possible Innovations: The next workshops use tools and methods associated with social innovation to begin to understand the breadth of possible innovations and the opportunities for grafting these to the current system or shifting the current system to accommodate the innovations.

Prototyping Solutions: In the next stage, workshops use design thinking to try out new ideas in the community by working with Lab Team member organizations and other community groups.

[13] Westley, F., Laban, S. (2015)

Over the course of two years, the Innovations Lab Team will create and implement strategies and tactics to reduce mental health stigma and increase cultural protective factors that lead to mental health among Latinos. Through a process of trial, error, observation and reflection, the Social Innovation Lab will create:

- New networks and teams
- Changed understandings, mindsets and logics
- New language around mental health
- Changed relationships and dynamics
- New capacities
- New commitments and actionable strategies
- New experiments, actions, and programs

Working with the five founding Lab partners (On The Move, Humanidad, Latinos Service Providers, Raizes Collective and North Bay Organizing Project) and potentially with multiple partners from faith communities, cultural groups, mental health organizations, family resource centers, schools and neighborhoods, **the Innovations Lab Team will implement at least three different prototype interventions targeting stigma and cultural protective factors.** Over the course of two years these prototype interventions **will engage at least 500 Latino community members** in both service strategies and in community-based participatory evaluation. Each prototype intervention will include an evaluation plan to determine its potential merits, future applications and areas for development.

Phase 4: Document & Share Learnings (Months 34-36)

The last two months of the *Nuestra Cultura Cura* Social Innovations Lab will be used to create a final evaluation report that will document the Social Innovations Lab process and summarize learnings, strategies, successes, failures and promise of prototypes attempted during the project.

The Lab Team will create a messaging plan to disseminate the final evaluation report and will employ its team members' networks to share learnings at local, regional, and state levels with policymakers, funders, mental health systems leaders and other community leaders/activists.

Appropriateness of selected approach

OTM's *Nuestra Cultura Cura* Social Innovations Lab makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

Sonoma County has been unable to overcome our current collective inability to reduce stigma around mental health and to increase Latinos' access to culturally relevant mental health services. Taking a collaborative approach with five diverse, Latino-serving organizations to develop culturally-responsive mental health services for the Latinx community is an expansion of the community-based participatory research led by On The Move in 2016. The Social Innovation Lab approach will allow Latino community leaders to create their own solutions that honor Latino culture and values and that facilitate relationships, shared understanding and shared responsibilities. Currently, Social Innovation Labs around the world are working across a range of sectors with public service, education and health being the primary focus areas. This will be one of the first applications of a Social Innovation Lab applied to mental health for the Latinx community.

Number of individuals expected to be served annually

The *Nuestra Cultura Cura* Social Innovations Lab is estimated to increase access for at least 500 Latino community members who are underserved, unserved or inappropriately served by engaging them in the prototypes of culturally relevant mental health strategies designed and implemented by the Social Innovations Lab Team. These engagements will focus on prevention and early intervention strategies addressing mental health challenges and reducing the stigma of mental health. The number of Latino community members that will engage in services under

this proposal was reached by analyzing OTM's historical success in conducting community outreach and engagement of the Latinx community members in other services and programs offered in Sonoma County. Given the potential reach of the project and the intent to pilot multiple interventions, the estimate that 500 Latino community members will be engaged is a reasonable assumption.

Population Description

OTM's *Nuestra Cultura Cura* Social Innovations Lab will engage Latinos living in Southwest Santa Rosa, West Sonoma County, Sonoma Valley and Healdsburg. Eighty-eight percent of Latino immigrants to Sonoma County hail from Mexico, and many arrive with limited education; 42% of Sonoma's Latinx population today is foreign born.

Latinos living in these communities face major challenges: from health and housing to health insurance and income, the Latinos trail the County average in all major indicators. The struggles are many: four in ten adults lack high school diplomas and typical Latino worker earns only about $21,695, which is far below the poverty line for a family of four. More than half of housing units in these neighborhoods are rented, and the average size of households living in rental housing is among the county's highest, suggesting overcrowded living conditions. Adults must direct the lion's share of their time and energy to securing the basics – essentials like nutritious food, medical care, and a place to live. The struggle to stretch low wages far enough to make ends meet and to navigate the daily challenges of life in high-poverty neighborhoods exacts a high cost: the chronic stress of insecurity causes excessive wear and tear on the heart and blood vessels, weakens immunity, frays relationships, and erodes psychological health. The effects of prolonged poverty, particularly in the early years, on children's well-being are grave and long-lasting.[14]

Research on Innovation Component

A) Distinguishing aspects of the project

The *Nuestra Cultura Cura* Social Innovations Lab has two distinct components that meet the criteria for Innovations funding: the application of Social Innovations Labs paired with the overarching model of culturally competent mental health services that is the foundation of the La Plaza framework. Both aspects of the project are making a change to an existing practice in the field of mental health. Social Innovations Labs have been utilized to solve some of the world's most pressing problems, and mental health has been identified as a focus area that has benefited from this approach. However, based on extensive literature reviews and internet searches OTM has learned that the Social Innovation Lab model has not been utilized to 1) Focus on the unique mental health needs of the **Latinx Community**; and 2) Bring **community members themselves** into the center of Social Innovation Lab leadership, design, planning and implementation process.

1) **Focus on Latinx Community:** The *Nuestra Cultura Cura* Social Innovations Lab will specifically focus on the unique, cultural needs of the Latinx community surrounding mental health, as a means to raise awareness, reduce stigma and increase access to mental health support. Although a handful of examples were found that integrated Social Innovation Labs into the field of mental health, they were conducted through large institutions such as the

[14] Burd-Sharps, S., Lewis, K. A Portrait of Sonoma County. Sonoma County Human Development Report 2014. Measure of America.

American Psychiatric Association[15] ,New York City[16], Stanford Business School[17], and Harvard University[18], and were far too large in scale to focus specifically on the Latinx community.

2) **Community members at the center of Social Innovation Lab leadership:** The *Nuestra Cultura Cura* Social Innovations Lab will bring Latinx community members themselves into the project's leadership, design, planning and implementation. Any examples of Social Innovations Labs focused on mental health were designed and led by large institutions, which centered on an "expert model" of leadership and implementation in which existing leaders in government, business, technology and clinical psychology led the entire process. Although university programs also integrated students and alumni entrepreneurs into the center, they did not directly engage the community in the design and implementation of their Social Innovation Lab.

   Although representatives from organizations will be engaged in the *Nuestra Cultura Cura* Social Innovations Lab in order to better influence the current mental health system, at the center of the project will be a community-based Innovations Lab Team, made up of intergenerational, Latinx community leaders who will self-determine the strategic direction of the Innovation Lab, collect and analyze data, and recommend and implement the service delivery strategies.

La Plaza, a community-based model based on culturally competent mental health services, will provide the organizing structure of the *Nuestra Cultura Cura* Social Innovations Lab. The design of La Plaza offers further evidence of this project meeting the criteria for Innovations Funding.

- **Integrating community-based and traditional mental health services together:** *La Plaza* itself meets criteria for Innovations Funding by providing a change to an existing practice in the mental health field. Very little evidence was found of a Latinx-based, community center that focuses on mental health. *La Plaza's* approach meets criteria for Innovations Funding by providing another change to an existing practice in the mental health field. One example of a Latinx community mental health center was found in Salt Lake City[19], however the Center focuses solely on increasing access to **traditional and clinical** mental health services for Latinos. An overarching community-based mental health strategy was also found in Cuba[20], but the strategy also focused specifically on medical, clinical and psychiatric approaches.

  La Plaza is set apart from these and other mental health models by emphasizing traditional mental health practices and cultural experiences that empower the Latinx community to recognize their own ability to heal. As a specific Innovations project, the *Nuestra Cultura Cura* Social Innovations Lab and its prototype strategies will create a welcoming setting that will reduce mental health stigma, create appropriate, culturally-based wellness activities and provide a bridge to a variety of mental health resources.

- **A Latinx-led, multi-disciplinary approach to addressing minority mental health disparities:** *La Plaza* also meets criteria for Innovations Funding by providing a change to an existing practice in the mental health field through offering a combination of multiple initiatives meant to address mental health disparities for minorities. Significant research has taken place to determine strategic initiatives that address mental health disparities for minorities. Initiatives

[15] https://www.psychiatry.org/psychiatrists/education/mental-health-innovation-zone/psychiatry-innovation-lab

[16] https://thrivenyc.cityofnewyork.us/#_usebetterdata

[17] https://www.stanfordbrainstorm.com/

[18] https://innovationlabs.harvard.edu/

[19] https://latinobehavioral.org/

[20] Pan American Health Organization. Innovative mental health programs in Latin America and the Caribbean. Washington, DC: PAHO. 2008. http://www1.paho.org/hq/dmdocuments/2008/MHPDoc.pdf

have included increased community representation on policy-making boards, provision of training in cultural sensitivity for providers, recruitment of minority professionals and/or paraprofessionals from the community, incorporation of healers and healing practices of ethnic communities into the mental health system, development of ethnic-specific service agencies in the community, and provision of treatments and programs matched to clients' ethnic backgrounds.[21] However research found that these initiatives are typically "siloed" as single, individual efforts. *La Plaza* provides a unique combination of several proven initiatives including representing Latinos as leaders, engaging Latinx mental health professionals and/or paraprofessionals from the community, incorporating Latinx healers and healing practices, integrating Latinx-specific service agencies into programming, and providing treatments and programs matched to the Latinx culture.

B. Investigation of existing approaches and identification of gaps in research and evidence

On The Move conducted extensive internet research on Social Innovations Labs by reading **literature reviews, on-line examples of existing practices implemented in the US and globally, and review appendixes.** Research included (but was not limited to):

- A wide range of reviews and existing practices from the leading educational institutions implementing Social Innovations Labs, including the *Stanford Center for Innovation*[22], *Harvard Innovation Labs*[23], *UC Berkeley School of Social Welfare*[24] *and University of Colorado's National Mental Health Innovation Center*[25]*.*
- Databases of existing Social Innovations Lab practices, such as the *Mental Health Innovation Network*[26], an online community of mental health innovators, researchers, practitioners and donors.
- Annual Reports and existing practice databases from institutions who fund Social Innovation Labs nationally and globally, such as *Ashoka*[27,28]*, Reos Partners*[29] and *Hitachi*[30].
- Reports and existing practice databases from leading mental health institutions, including *American Psychiatric Association*[31,32] and the *International Association of Applied Psychology*[33]*.*
- A *United Nations* report provided by *New York City's THRIVE Mental Health Initiative*[34]*.*

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[21] Wallen, Jacqueline, Ph.D. *Providing Culturally Appropriate Mental Health* The Journal of Mental Health Administration. Fall 1992. https://page-one.springer.com/pdf/preview/10.1007/BF02518993

[22] https://www.gsb.stanford.edu/faculty-research/centers-initiatives/csi

[23] https://innovationlabs.harvard.edu/

[24] https://socialwelfare.berkeley.edu/research

[25] http://mentalhealthinnovation.org/

[26] https://www.mhinnovation.net/innovations

[27] https://www.ashoka.org/en/our-network

[28] https://www.ashoka.org/en-in/files/mapping-emergingparadigminmentalhealthpdf

[29] https://reospartners.com/our-work/impact-report/

[30] https://social-innovation.hitachi/en-us/case_studies/

[31] https://www.psychiatry.org/psychiatrists/education/mental-health-innovation-zone

[32] https://www.psychiatryinnovation.com/alumni

[33] https://iaapsy.org/about/apaw/

[34] https://iaapsy.org/iaap-and-the-united-nations/reports-meetings-events/new-york-city-thrive-mental-health-initiative-presented-at-the-united-nations/

- The book, *The Social Labs Revolution – a New Approach to Solving Our Most Complex Challenges*, by Zaid Hassan[35].

When engaging in the above research, OTM searched for any existing practices or focused efforts surrounding Social Innovations Labs specific to the Latinx community. Throughout this research, OTM found gaps in the literature or existing practices, discovering that the Social Innovation Lab model has not been utilized to focus on the **unique mental health needs of the Latinx Community**. Extensive research was also conducted to explore if community members themselves have been at the center of Social Innovation Labs focused on mental health. On The Move found no evidence of any **community engagement within Social Innovation Labs' leadership, design, planning and implementation process**. Lastly, OTM's research found that there were very few existing practices of community-based mental health centers or projects. The few examples of community-based mental health centers found only focused on traditional, clinical mental health support, therefore uncovering a lack of any **multi-disciplinary approach of addressing minority mental health disparities** that offer a combination of strategies meant to address mental health disparities for minorities, in one central location. On The Move's INN Project will address all of these gaps found in research.

Beyond the exhaustive internet research of literature reviews and existing practices of Social Innovation Labs, OTM spoke to various community partners and leaders who focus on working with the Latinx community surrounding mental health. No partner was aware of any local or national Social Innovations Lab projects being applied to the Latinx community and mental health.

Learning Goals/Project Aims

One broad objective of MHSA Innovation is to promote learning that contributes to the expansion of effective practices in the mental health system. The *Nuestra Cultura Cura* Social Innovation Lab has identified two principal learning goals that will significantly improve the way in which the mental health service delivery system supports Latinos in Sonoma County.

1. What more can we understand about the unique challenges that inhibit Latinx community members from accessing mental health services in Sonoma County?
2. How might using culturally-specific interventions and language improve the quality of mental health services for the Latinx community?

The chart below illustrates how each learning goal relates to key program elements that are either adapted, new or changed.

Learning Goal	Key Program Elements	Approach
What more can we understand about the unique challenges that inhibit Latinx community members from accessing mental health services in Sonoma County?	"Formation of Social Innovation Lab Team and Iterative Design Process" component has 20 Social Innovation Lab team members defining community mental health challenges and barriers to accessing mental health services..	Adapted: Collaboration of five Latino-serving agencies, diverse representation from the community, including those with lived experience are engaged as Social Innovation Lab team members.
How might using culturally-specific interventions and	"Prototyping of Culturally-Relevant Mental Health Interventions" component of the	Change: These community interventions will be developed by the Social

[35] https://www.bkconnection.com/static/Social_Labs_EXCERPT.pdf

language improve the quality of mental health services for the Latinx community?	project has the Social Innovation Lab Team developing, piloting, and evaluating culturally-based interventions.	Innovations Lab Team comprised of diverse members. Focus will be on community empowerment to self-determine best intervention for specific community challenges.

Evaluation or Learning Plan

As detailed in the table below, the *Nuestra Cultura Cura* Social Innovation Lab has set four desired outcomes that relate directly to the selected primary purposes:

Increase access

- **Short-term:** Lab members identify core problems, symptoms and contributing factors that inhibit Latinx community members from accessing mental health services in Sonoma County
- **Long-term:** Latinx adults and youth are more willing and able to access mental health that address challenges and barriers

Increase quality

- **Short-term:** Latinx adults and youth participate in mental health interventions that are culturally and linguistically appropriate
- **Long-term:** Latinx adults and youth experience strengthened cultural protective factors and reduced depression and anxiety

Primary Purpose	Desired Outcome(s)	Indicators	How Measured
Increase access to unserved or underserved groups	**Short-term:** Lab members identify core problems, symptoms and contributing factors that inhibit Latinx community members from accessing mental health services in Sonoma County **Long-term:** Latinx adults and youth are more willing and able to access mental health that address challenges and barriers	Number of Lab Members who report a deeper understanding of root causes and potential solutions to barriers to access Number of Latinx adults and youth who indicate increased willingness and ability to access services that support mental health	Documentation of research and analysis process Participatory Evaluation process with Lab Members Culturally appropriate, validated tools contextualized by Social Innovations Lab Team (may include participant surveys, key informant interviews, and/or focus groups)

Increase quality of mental health services, including better outcomes	**Short-term:** Latinx adults and youth participate in mental health interventions that are culturally and linguistically appropriate **Long-term:** Latinx adults and youth experience strengthened cultural protective factors and reduced depression and anxiety	Number of interventions that are designed, implemented and evaluated Number of Latinx adults and youth who participate in prototype interventions Number of participants reporting that interventions were culturally and linguistically appropriate Number of participants reporting an increased connection with cultural protective factors Number of participants reporting decreased severity in symptoms of depression and anxiety	Documentation of prototype process Participation logs Culturally appropriate, validated tools contextualized by Social Innovations Lab Team (may include participant surveys, key informant interviews, and/or focus groups)

Evaluation methods will be developed by Lab Team members, with the support of the project facilitator and OTM's expert evaluation consultant. All evaluation activities will be implemented by the Lab Team members and the evaluation consultant to gather information to support the project's two learning goals and to measure the overall impact of the project on stigma and mental health outcomes for Latinos.

The project consists of two key elements that will be evaluated as follows:

1. **Formation of Social Innovation Lab Team & Iterative Design Process**: Lab Team members will provide ongoing input through Participatory Evaluation as to the effectiveness of the Social Innovation Lab process, including feedback as to the make-up and diversity of team membership; quality of process management/facilitation; and their perceptions of inclusivity and team dynamics. In addition, the Participatory Evaluation process will document the research and analysis conducted by the Team and include key informant interviews with Lab Team Members to gauge the extent to which Lab Team Members report a deeper understanding of root causes and potential solutions to barriers to access.

   In the longer term, the Lab Team will create and implement evaluation tools to measure Latinx community members increased willingness and ability to access services that support mental health, which may include participant surveys, key informant interviews, and/or focus groups developed in partnership with the project evaluator.

2. **Prototyping of Culturally-Relevant Mental Health Interventions**: Each prototype intervention will be designed by the Lab Team with predetermined, specifically-tailored outcome goals and data collection methods that will include baseline data that will be used to compare and demonstrate change. In addition, the Team will use a set of standardized indicators to measure the effectiveness of each intervention, including the number of Latinx adults and youth who participate in interventions; number of Latinx adults and youth who indicate increased willingness and ability to access services that support mental health; number of participants reporting that mental health interventions were culturally and

linguistically appropriate: number of participants reporting an increased connection with cultural protective factors; number of participants reporting decreased severity in symptoms of depression and anxiety. Lab Team Members will work with the project evaluator to identify, select and adapt culturally appropriate, validated data collection tools, which may include participant surveys, key informant interviews, and/or focus groups.

Section 3: Additional Information for Regulatory Requirements

Contracting

Sonoma County Department of Health Services (DHS) will contract with On the Move for the proposed three-years of Innovation funding award. On the Move has an internal staff evaluator to lead and conduct the evaluation.

The MHSA Coordinator of the Sonoma County DHS Behavioral Health Division will be the main point of contact to monitor progress of *Nuestra Cultura Cura* and assure contract compliance per County and State regulations. The County may provide technical support in program delivery and evaluation, fiscal reporting and program reporting to the County. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and Innovation regulations. In addition, On the Move will be expected to submit quarterly reports that include quantitative (number of clients served, demographics) and qualitative data (narrative reporting that includes findings, challenges, and solutions).

As the administrator for the *Nuestra Cultura Cura* project, On the Move will have Partner Agency Support Contracts with the four community-based nonprofits collaborating on this project. In addition, OTM will contract with a project facilitator for the formation of the Social Innovation Lab Team and an evaluation consultant to oversee the implementation of the evaluation.

Community Program Planning

The County has robust stakeholder engagement in the MHSA Community Program Planning process. This includes the MHSA Steering Committee, Stakeholder Committee, county staff and contractors and any other interested parties. The County's MHSA Steering Committee is a key stakeholder and the committee is comprised of 27 diverse community members, including consumers, family members, TAY, ethnic and LGBTQ+ representation, various public sector personnel and advocates (see Appendix A for membership representation).

Since January of 2019, The MHSA Steering Committee has met at least quarterly to participate in shaping the mental health system of care funded by MHSA. In the summer of 2019, the MHSA Steering Committee established an Innovation Subcommittee to develop an inclusive community process that would solicit innovative project proposals, develop and apply a selection criterion for the incoming proposals and make a recommendation to award Innovation funds to selected projects. The Community Program Planning process is outlined below:

2019	Task
May-June	Understand Innovation regulations and requirements, discuss and define community planning process.

July	**Develop and adopt community application, scoring criteria and FAQs to solicit Innovation Project Ideas.**
Aug	**Establish a calendar of community meetings for outreach and to inform the community about the Innovation opportunity; develop community presentation; conduct outreach for community meetings.**
Sept	**Conduct five community meetings in strategic geographic locations throughout the county to inform interested parties about MHSA and Innovation opportunity, including requirements, application form and selection criteria.**
Oct	**Received sixteen Innovation applications from the community; Innovation Subcommittee members reviewed and scored all applications based upon previously agreed upon selection criteria; Innovation Subcommittee held 2 full day meetings to discuss applications and arrive at consensus on prioritized projects and developed recommendation for funding.**
Dec	**Presented recommendation to MHSA Steering Committee and Mental Health Board (public meeting).** **Recommendation forwarded to the Behavioral Health Director and the Department of Health Services administration.** **Innovation applicants notified of status; meetings convened with approved projects to further develop their proposals.**

In the table below provides details about the dates and locations of the community meetings:

Date	Time	Location
September 4, 2019	**10:30am – 12:30pm**	**Guerneville Regional Library** **14107 Armstrong Woods Rd., Guerneville** **(West County)**
September 4, 2019	**3:00pm – 5:00pm**	**Sonoma Valley Regional Library** **755 West Napa Street, Sonoma** **(East County)**
September 11, 2019	**9:00am – 11:00am**	**DHS Administration** **Santa Rosa Conference Room,** **1450 Neotomas Ave., Santa Rosa** **(Central County)**
September 11, 2019	**1:00pm – 3:00pm**	**Petaluma Health District,** **1425 N. McDowell Blvd., Rm 100,** **Petaluma** **(South County)**

September 13, 2019	**1:00pm – 3:00pm**	**Healdsburg Library 139 Piper St., Healdsburg (North County)**

The table below provides the 16 applicant names and project titles.

Applicant	Project Title
Action Network (Sonoma County Indian Health Project, Redwood Coast Medical Services, Community Wellness Coalition)	**Implement Community Resilience Leadership Model on the Rural Redwood Coast**
Brief and Strategic Integrated Counseling Services (BASICS) [First Responder Support Network (FRSN)]	**Approach to address workplace trauma among Sonoma County's first responders**
Buckelew Programs (Aldea Children and Family Services, On the Move/VOICES)	**Early Psychosis Intervention Care EPIC Program (EP LHCN)***
Center for Innovation and Resources	**Effective, Equitable, Expanded (3E) Mental Health in Sonoma County Project**
Early Learning Institute	**Instructions Not Included (INI) with Dads Matter***
First 5 Sonoma County	**Promoting Early Relational Mental Health: New Parent TLC***
Hanna Institute [Center for Well Being (CWB), International Trauma Center (ITC)]	**"Bridging Gaps in Mental Health Care in Vulnerable Communities"**
On the Move/VOICES (La Plaza, Humanidad, Latino Service Providers, Raizes Collective and North Bay Organizing Project)	**Nuestra Cultura Cura Social Innovations Lab***
Petaluma Health Center	**Psychiatric Nurse Practitioner Residency**
Petaluma People Services Center	**Manhood 2.0**
Side by Side	**New Residents Resource Collaborative**

Social Advocates for Youth	**Innovative Grief Services**
Social Advocates for Youth	**Street-Based Mental Health Outreach**
Sonoma County Human Services Department Adult & Aging (and Santa Rosa Community Health)	**Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)**
Sonoma County Indian Health Project	**Primary and Behavioral Health Care Integration Program with Traditional Native Healing Practices**
Sonoma County Public Health Maternal Child and Adolescent Health	**Trauma-Informed Approach in Public Health Nursing**

The table below details the timeline of events in 2020 and 2021 for preparing the Innovation projects proposals for public review and approvals from the Board of Supervisors and MHSOAC.

2020	Task
Feb-Mar	Prepared draft proposals for submission to Mental Health Services Oversight and Accountability Commission (MHSOAC) for technical assistance.
Mar	Submitted draft proposals to MHSAOC for review and technical assistance
Apr	Posted MHSA 2020-2023 Three-Year Plan with the five prioritized Innovation proposals for 30 days
May	Held public hearing at the Sonoma County Mental Health Board meeting. No substantive comments were received about the Innovation proposals.
June	Sonoma County Board of Supervisors approved the MHSA 2020-2023 Three-Year Plan that included the five prioritized Innovation proposals.
Sept/Oct	Received feedback and technical assistance from MHSOAC and incorporated feedback into proposals.
Nov	Posted Innovation proposals for 30-day public review period. On November 13, 2021.
Dec	Held public hearing at the Sonoma County Mental Health Board meeting on December 15, 2020. No substantive comments were received about the Innovation proposals.
2021	**Task**

Feb	**Resubmit projects to MHSOAC for approval.** **February 23, 2021 submit board item for Board of Supervisors review and approval.**

On November 13, 2020, the County posted 4 proposed Innovation Projects, Instructions Not Included, CCERP, New Parent TLC and Nuestra Cultura Cura for the 30-day public review period. Followed by a public hearing hosted by Sonoma's Mental Health Board on December 15, 2020. No substantive comments were received on any of the projects during the 30-day review period or at the public hearing.

For the review period, the County's process is to post the project proposal on the Department's website/Behavioral Health Division webpage and send notification to MHSA Steering Committee members, MHSA Stakeholder Committee, over 2000 contacts on the MHSA Newsletter list, County staff, contractors and any other interested parties.

In addition to the County's community program planning process, each of the applicants were required to develop their proposed projects with consumer and community input to validate the need among the population and that the innovation proposed was a feasible and strategic approach to the defined community/mental health challenge.

On the Move (OTM) has actively engaged Latinos in identifying their needs and desired supports over the last three years through the planning and formation of the *La Plaza Project.* OTM Sonoma County initiated its first cohort of Latino community advocates in 2016, which took on the task of defining key issues surrounding mental health in the Latino community. These emerging leaders conducted key informant interviews, in-depth research to better understand to what extent mental health services are available but not accessed by the Latino community, how weak linkages between community and County services impact access, and the scope of the shortage of bilingual and bicultural mental health practitioners in the region. Their research led them to conduct an extensive storytelling project with 55 Latino community members, through which they learned that *while stigma and a lack of bilingual services discourage many Latinos from seeking out clinical mental health services, many Latinos desire to find healing through community and cultural expressions and not through the clinical mental health system.*

These initial findings about mismatch in services and needs have been echoed repeatedly in the research and development of the Sonoma County *La Plaza* Project*,* a Latino-focused Center that emphasizes the use of cultural strengths to raise awareness and reduce mental health stigma in Southwest Santa Rosa in Sonoma County. In April 2018, a cohort of young Latino community advocates led a town hall process for over 200 Latino students, parents, seniors and service providers to create a visual representation of what the new *Plaza* should be: a space where community members could rebuild cultural protective factors and improve mental health through art, wellness, spirituality, and social connections.

The lessons learned in that process was that health and social problems occur in the context of family, community and culture. Outside of *La Plaza*, Sonoma County has done little to engage Latinos in creating mental health strategies that acknowledge and integrate cultural values and family preferences. It is imperative that Latinos are given the opportunity to define and solve problems most relevant to them and to generate new cultural norms that mirror the values and aspirations that community members have for their children. Because lasting culture change requires the community to embrace new ways of thinking and behaving, change must be centered on the community. Diverse community members—those most affected by adversity; those committed to improving

the lives of children and families; and those ready and willing to offer resources that will support small, iterative layers of change—must engage in hopeful, creative dialogue about how they want things to change, and then begin and sustain the process with small changes that will build into larger transformations.[36]

In addition to the program planning that has already been completed, Social Innovation Lab Team members comprised of diverse community members, will continue to collect data from the broader community to develop, implement and evaluate culturally-appropriate mental health interventions.

MHSA General Standards

A. Community Collaboration

Throughout its programming, On the Move, (OTM) has intentionally collaborated with multiple stakeholders in order to increase its effectiveness and create systemic improvements for underserved communities. OTM has successfully implemented and managed dozens of MOUs, collaborative grants and County-wide committees with non-profit partners, government agencies, elected officials, foundations and community members. The *Nuestra Cultura Cura* Social Innovation Lab will bring together at least five community organizations that specialize in community organizing and community mental health.

B. Cultural Competency

On the Move brings fifteen years of rich experience providing community-based programming that empowers Latinos in Napa and Sonoma Counties. Programming has ranged from Latinx Youth Leadership Academies serving over 200 youth annually; Parent University and Family Resource Centers serving over 2,000 Latinx families annually, a Latinx LGBTQ Inclusion Initiative engaging over 200 youth, families and service providers annually; and Citizenship Legal Services, providing immigration support and outreach for over 20,000 Latinx immigrants.

Connection, coping skills, cultural identity and community are key assets that improve social and emotional wellness. The Social Innovation Lab will pair traditional health practices with cultural arts experiences that empower communities to recognize their own ability to heal. The Social Innovation Lab and its prototype strategies will create a welcoming setting that will reduce mental health stigma, create appropriate, culturally-based wellness activities and provide a bridge to a variety of health resources.

C. Client-Driven

Throughout its work with underserved communities, OTM has learned that its most successful methods of increasing access to critical services involve developing community-based leadership in which trusted, emerging leaders are the forefront of all outreach, program design and implementation efforts. OTM has led dozens of community forums, town hall meetings, and needs assessments in order to ensure a community-driven approach is implemented to solve our communities' most pressing inequities and needs.

The *Nuestra Cultura Cura* Social Innovations Lab will bring Latinx community members themselves into the project's leadership, design, planning and implementation. Although influential decision-makers will be engaged in the *Nuestra Cultura Cura* Social Innovations Lab in order to better influence the current mental health system, at the center of the project will be a community-based Innovations Lab Team, made up of intergenerational, Latinx community

[36] Porter, L., Martine, K., Anda R. (2016) *Self Healing Communities: A Transformational Process Model for Improving Intergenerational Health.* Robert Wood Johnson Foundation.

leaders who will self-determine the strategic direction of the Innovation Lab, collect and analyze data, and recommend and implement the service delivery strategies.

D. Family-Driven

The Social Innovation Lab will involve parents and family members of children and youth with mental health challenges in identifying needs, creating new prototype programs and strategies gathering evaluation data to assess the impact and potential of pilot programs.

E. Wellness, Recovery, and Resilience-Focused

La Plaza, the hub of the *Nuestra Cultura Cura* Social Innovation Lab, is many things at once: a place for gathering, the creation of a new cultural norm for wellness, a process by which people are taught to design and lead healing activities for themselves and others, and a practice space for emerging leaders to try out new skills and roles in the community.

La Plaza brings together community leaders and organizations to create a "Tapestry of Wellness", a collection of "strands" that create culturally based paths to wellness. Within these strands, La Plaza offers a broad range of ongoing and one-time activities, including art, crafts, exercise and cooking classes, conversation groups, dance and music activities, parent cafes, nature walks and gatherings with traditional healers representative of Latino culture. Activities and implementation of services will be led by community members themselves, a combination of both professionals and peers.

F. Integrated Service Experience for Clients and Families

A top priority for the *Nuestra Cultura Cura* Social Innovation Lab prototype programs is to create family-focused interventions that are culturally relevant to Latinos and that strengthen relationships between people with mental illness and their families by reducing stigma and addressing trauma.

Cultural Competence and Stakeholder Involvement in Evaluation

The *Nuestra Cultura Cura* Social Innovation Lab will be led by the Lab Team, which will be made up of Latinx community stakeholders. The Lab Team will work with the expert facilitator and OTM's evaluation consultants to design culturally appropriate, meaningful data collection strategies that will engage program participants in offering feedback as to the impact and delivery methods of each prototype intervention. Furthermore, the Lab Team will be involved in discussing the evaluation findings and dissemination to community stakeholders, providers and policy-makers.

Innovation Project Sustainability

The MHSA Coordinator, with the assistance of the MHSA Innovation Subcommittee, will host an annual meeting to review progress of the active Innovation Projects. Each Innovation Project will be required to submit an annual evaluation report on findings to date. These annual reports will be reviewed and discussed among the Innovation Subcommittee members who will focus on successful outcomes and challenges that may prompt the need for technical assistance and additional resources.

Specific to this proposed project, the Sonoma County Behavioral Health Division will work in collaboration with the OTM leadership and look holistically at the success of the project. Key indicators include the ability to implement and evaluate prototype interventions successfully and project outcomes related to the stated learning goals.

Data driven decision-making will determine if the project is promising and if additional time is indicated to further develop definitive results for the project. If necessary, a criteria will be developed to determine if an Innovation project should be extended for up to two years with continued Innovation funding (up to five years total) or supported with alternative funding. Projects can be supported in whole or focused on specific components that are particularly successful in addressing the mental health challenge for the community.

Once Innovation funding has ended, the project may be considered for MHSA Prevention and Early Intervention funding and/or pursue funds from other Community Based Organizations and/or public grants. The three hospital systems: Kaiser Permanente Community Benefits, Sutter Health and St. Joseph's Health System often pool funding to support local projects that are within their respective mission statements. This particular Innovation Project can be supported in whole or focused on specific interventions that are particularly successful in addressing the mental health challenge for the Latinx community. It will be necessary to consult with the full MHSA Steering Committee, Behavioral Health Division administration, and/or other community resources such as local foundations, and the Board of Supervisors.

Continuity of Care

Whether or not individuals with serious mental illness will receive services through this project will be determined by the scope and focus of the program prototypes designed and implemented by the Social Innovation Lab Team. However, if the project involves services to the severely mentally ill, Humanidad will work with the County to assure continuity of care for any and all individuals receiving mental health services beyond this funding.

Communication and Dissemination Plan

As described above, the last two months of the *Nuestra Cultura Cura* Social Innovations Lab will be used to create a final evaluation report that will document the Social Innovations Lab process and summarize learnings, strategies and the successes, failures and promise of prototypes attempted during the project.

The Lab Team will create a messaging plan to disseminate the final evaluation report and will employ its team members networks to share learnings at local, regional, and state levels with policymakers, including the Sonoma County Mental Health Board and Sonoma County MHSA Steering Committee; funders; mental health systems leaders; and other community leaders/activists through convenings and Latinx-focus behavior health conferences.

KEYWORDS for search

1. Latino
2. cultural protective factors
3. social innovation labs
4. culturally relevant mental health practices

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TIMELINE

	2021/22				2022/23				2023/24			
Tasks	**Q1 (Jul-Sep)**	**Q2 (Oct-Dec)**	**Q3 (Jan-Mar)**	**Q4 (Apr-Jun)**	**Q5 (Jul-Sep)**	**Q6 (Oct-Dec)**	**Q7 (Jan-Mar)**	**Q8 (Apr-Jun)**	**Q9 (Jul-Sep)**	**Q10 (Oct-Dec)**	**Q11 (Jan-Mar)**	**Q12 (Apr-Jun)**
Award of Innovation Project(s)	X											
Social Lab Planning and Development	X	X	X									
Community Engagement	X	X	X	X	X	X	X	X	X	X	X	X
Project Implementation		X	X	X	X	X	X	X	X	X	X	X
Evaluation			X	X	X	X	X	X	X	X	X	X
Dissemination of Results												X

Section 4: INN Project Budget and Narrative

Note: Sonoma County has $822,000 in MHSA Innovation dollars that are subject to reversion on June 30, 2021. Sonoma County is submitting four Innovation proposals simultaneously, including this proposal for Nuestra Cultura Cura Social Innovation Lab, to the MHSOAC in February 2021 following the public hearing on December 15th at the Sonoma County Mental Health Board meeting. The combined total of the four Innovation proposals that are being submitted to the MHSOAC in February 2021 is $2,783,034.

Personnel Costs	**FY21/22**	**FY22/23**	**FY23/24**	**TOTAL**
1. Salaries	$85,385	$73,125	$43,990	$202,500
2. Benefits (18%)	$15,370	$13,163	$7,918	$36,450
3. Direct Costs	$100,755	$86,288	$51,908	$238,950
4. Indirect Costs (12%)	$12,091	$10,355	$6,229	$28,674
5. Total Personnel Costs	$112,845	$96,642	$58,137	$267,624
Operating Costs	**FY21/22**	**FY22/23**	**FY23/24**	**TOTAL**
6. Direct Costs	$3,000	$3,000	$3,000	$9,000
7. Indirect Costs	$360	$360	$360	$1,080
8. Total Operating Costs	$3,360	$3,360	$3,360	$10,080
Consultant Costs/Contracts	**FY21/22**	**FY22/23**	**FY23/24**	**TOTAL**
9. Direct Costs	$34,000	$34,000	$31,000	$99,000
10. Indirect Costs	$4,080	$4,080	$3,720	$11,880
11. Total Consultant Costs	$38,080	$38,080	$34,720	$110,880
Other Expenditures (please explain in budget narrative)	**FY21/22**	**FY22/23**	**FY 23/24**	**TOTAL**
12. Social Innovations Lab Participant Stipends	$24,000	$24,000	$0	$48,000
13. Partner Agency Support Contracts	$100,000	$100,000	$100,000	$300,000
14. Total Other Expenditures	$124,000	$124,000	$100,000	$348,000
Budget Totals				
Personnel Costs	$112,845	$96,642	$58,137	$267,624
Direct Costs (lines 6+9)	$37,000	$37,000	$34,000	$108,000
Indirect Costs (lines 7+10)	$4,440	$4,440	$4,080	$12,960
Non-recurring Costs	$0	$0	$0	$0
Other Expenditures (line 14)	$124,000	$124,000	$100,000	$348,000
Total Innovation Budget	**$278,285**	**$262,082**	**$196,217**	**$736,584**

Budget Narrative

Salaries Direct Costs include: Project Director (0.5 FTE), Project Coordinator (1.0 FTE) and Outreach Coordinator (.25 FTE)
Salaries Indirect Costs at 12% cover overhead expenditures (administrative staff, insurance, etc.)

Operating Direct Costs include: $1,000 for travel annually for YR2, YR3 and YR4 + $1,500 for supplies
Operating Indirect Costs at 12% cover share of cost for rent, utilities, communications

Consultant/Contract Direct Costs include Project Facilitator ($22,000 YR2, $22,000 YR3, $15,000 YR4) and Evaluation Consultant ($12,000 YR2, $12,000 YR3, $16,000 YR4)

Consultant/Contract Indirect Costs at 12% include costs to develop, administer and monitor subcontracts.

APPENDIX A: MHSA Sonoma County MHSA Steering Committee, November 2020

First Name	Last Name	Industry	Representing
Claudia	Abend	Community at-large	Consumer, Family member
Mechelle	Buchignani	Law Enforcement	
Jessica	Carroll	MH, Social Services	Consumer, LGBTQ+
Sophie Marie	Clifford	Substance Abuse	Consumer, Latina, LGBTQ+
Mandy	Corbin	Education	Family Member
Christy	Davila	Social Services	
Angie	Dillon-Shore	0-5	LGBTQ
Jeane	Erlenborn	Education	
Cynthia	Kane Hyman	Education	
Ozzy	Jimenez	Businessman	LGBTQ, Latino
Erika	Klohe	MH, Community Benefits,	Family Member
Claire	McDonell	Education	Family Member, TAY
John	Mackey	Healthcare	Veteran
Shannon	McEntee		Consumer, TAY
Mike	Merchen	Law Enforcement	Family Member
Allison	Murphy	0-5	Family Member
Ernesto	Olivares	Social Services	Latino
Matt	Perry	Probation	
Ellisa	Reiff	Disabilities	
Kate	Roberge	MH, Disabilities, Workforce	Consumer, Peer
Kurt	Schweigman	Healthcare, MH	Native American
Kathy	Smith	Mental Health Board	Family member
Susan	Standen	Self-employed, MH peers	Consumer
Angela	Struckmann	Social Services	Family Member
Katie	Swan	Mental Health	Family Member, LGBTQ+, TAY
Sam	Tuttelman	Community at-large	Family member
Carol Faye	West	Peer	Consumer, Family member

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
April 22, 2021

Motion #: 1

Date: April 22, 2021

Time: 12:00 PM

Motion:

The Commission approves Fresno County's Innovation plan, as follows:

Name: California Reducing Disparities Project Evolutions

Amount: Up to $2,400,000 in MHSA Innovation funds

Project Length: Three (3) Years

Commissioner making motion: Commission Gordon

Commissioner seconding motion: Commission Wooton

Chair Ashbeck recused herself. Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
April 22, 2021

Motion #: 2

Date: April 22, 2021

Time: 12:01 PM

Motion:

The Commission approves Fresno County's Innovation plan, as follows:

Name: Suicide Prevention Follow-Up Call Program

Amount: Up to $1,000,000 in MHSA Innovation funds

Project Length: Three (3) Years

Commissioner making motion: Commissioner Wooton

Commissioner seconding motion: Commissioner Berrick

Chair Ashbeck recused herself. Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
April 22, 2021

Motion #: 3

Date: April 22, 2021

Time: 12:31 PM

Motion:

For each of the grants, the Commission authorizes the Executive Director to:

- Issue a Notice of Intent to Award EPI Plus Grants to the two highest scoring applicants in each category:
  - Santa Clara County- New or Existing and
  - Nevada County- Hub and Spoke
- 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 Applications

- Execute the contracts upon expiration of the protest period or consideration of protests, whichever comes first

Commissioner making motion: Vice Chair Madrigal Weiss
Commissioner seconding motion: Commissioner Boyd

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

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
April 22, 2021

Motion #: 4

Date: April 22, 2021

Time: 12:32 PM

Motion:

The Commission approves the March 25, 2021 meeting minutes.

Commissioner making motion: Vice Chair Madrigal Weiss

Commissioner seconding motion: Commissioner Berrick

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

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

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the April Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0
17MHSOAC074	$ 0
18MHSOAC040	$ 188,126
Total	**$ 188,126**

Contracts with Deliverable Changes

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Kai Le Masson

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

Total Contract Amount: $2,453,736.50

Total Spent: $**1,558,604.54**

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

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No **No**
Data Collection and Management Report	Complete	6/15/20	No

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21-3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21-6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	Not Started	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Not Started	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

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

MHSOAC Staff: Kai Le Masson

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

Total Contract Amount: $2,453,736.50

Total Spent: **$1,558,604.54**

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

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No **No**
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21-6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	Not Started	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Not Started	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

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: $1,257,008

Total Spent: **$1,068,882**

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

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

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
MAY 2021

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	9	19	**28**
Participating Counties (unduplicated)	5	17	**22**
Dollars Requested	$35,898,217	$38,292,894	**$74,191,111**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
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	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2020-2021	10	9	$15,855,948	6

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Humboldt	Resident Engagement & Support Team (REST)	$1,612,342	5 Years	12/17/2020	Pending
Under Review	Madera	Project DAD (Dads, Anxiety & Depression)	$930,401.56	5 Years	3/3/2020	Pending
Under Review	Orange	Multi-County Psychiatric Advance Directive Project	$13,015,717	4 Years	3/9/2021	Pending
Under Review	Shasta	Multi-County Psychiatric Advance Directive Project	$630,731	4 Years	3/9/2021	Pending
Under Review	Fresno	Multi-County Psychiatric Advance Directive Project	$500,000	5 Years	3/9/2021	Pending
Under Review	Mariposa	Multi-County Psychiatric Advance Directive Project	$517,274	4 years	3/9/2021	Pending
Under Review	Monterey	Multi-County Psychiatric Advance Directive Project	$1,978,237	4 years	3/9/2021	Pending
Under Review	Amador	Student Mental Health Support	$665,000	5 Years	3/22/2021	Pending
Under Review	Stanislaus	Early Psychosis Learning Health Care Network	$1,564,633	5 Years	4/7/2021	Pending
Under Review	Stanislaus	FSP Multi-County Collaborative	$1,757,146	4 Years	4/7/2021	Pending
Under Review	Yolo	Crisis Now Planning Request	$114,000	One time use	5/4/2021	Pending
Under Review	Merced	Transformational Equity Restart Program	$4,051,839	5 Years	3/19/2021	Pending
Under Review	Imperial	Holistic Outreach Prevention and Engagement (HOPE)	$2,829,494	3 Years	4/30/2021	Pending
Under Review	Colusa	Social Determinants of Rural Mental Health	$498,812	3 Years	5/5/2021	Pending
Under Review	Tri-Cities	Restorative Practices for Improving Mental Health	$949,957	3 Years	4/9/2021	Pending

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Butte	Physician Committed-Extension	$1,252,631	5 Years	4/12/2021	Pending
Under Review	Shasta	Hope Park	$1,750,000	5 Years	2/17/2021	Pending
Under Review	Modoc	Integrated Health Care for Individuals with SMI	$480,000	5 Years	3/2/2021	Pending
Under Review	Alameda	Community Assessment Transportation Team (CATT) Extension	$4,759,312	5 Years	3/25/2021	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Sonoma	New Parent TLC	$394,586	3 Years	10/6/2020	2/3/2021
Under Final Review	Sonoma	Instructions Not Needed	$689,860	3 Years	10/6/2020	2/3/2021
Under Final Review	Sonoma	Collaborative Care Enhanced Recovery Project (CCERP)	$998,558	3 Years	7/2/2020	2/3/2021
Under Final Review	Marin	From Housing to Healing, Re-Entry Community for Women	$1,795,000	5 Years	3/12/2021	4/20/2021
Under Final Review	Ventura	Mobile Mental Health	$3,380,986	3 Years	3/15/2021	4/26/2021
Under Final Review	Santa Clara	Community Mobile Response Program (CMR)	$27,949,227	5 Years	2/4/2021	4/13/2021
Under Final Review	San Luis Obispo	BH Education & Engagement Team (BHEET)	$610,253	4 Years	6/4/2020	5/4/2021
Under Final Review	San Luis Obispo	SoulWomb Project	$576,180	4 Years	6/4/2020	5/4/2021

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Santa Clara	Independent Living Empowerment Project	$990,000	3 Years	6/29/2020	4/19/2021

APPROVED PROJECTS (FY 20-21)			
County	Project Name	Funding Amount	Approval Date
San Mateo	Cultural Arts and Wellness Social Enterprise Café for Filipino/a/x Youth	$2,625,000	8/27/2020
Modoc	INN and Improvement through Data (IITD)-Extension	$91,224	10/12/2020
San Mateo	Co-location of Prevention Early Intervention Services in Low Income Housing	$925,000	11/16/2020
San Mateo	PIONEERS (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve)	$925,000	12/9/2020
Santa Clara	Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities	$1,753,140	2/25/2021
San Francisco	Culturally Congruent and Innovative Practices for Black/African American Communities	$5,400,000	3/25/2021
Sonoma	Nuestra Cultura Cura Social INN Lab	$736,584	4/20/2021
Fresno	Suicide Prevention Follow Up Call Program	$1,000,000	4/22/2021
Fresno	California Reducing Disparities Project Evolutions	$2,400,000	4/22/2021

DHCS Status Chart of County RERs Received
May 27, 2021 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated April 19th, 2021. This Status Report covers the FY 2016-17 through FY 2019-20 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review. FY 2017-18 RER data has not yet been incorporated into the Fiscal Reporting Tool due to format changes.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at https://mhsoac.ca.gov/resources/documents-and-reports/documents?field_county_value=All&field_component_target_id=46&year=all

On October 1, 2019, DHCS published a report detailing MHSA funds subject to reversion as of July 1, 2018, covering allocation year FY 2015-16 for large counties and 2008-09 for WET and CFTN funds, updating a July 1, 2018 report detailing funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). Both reports can be accessed at the following webpage:

https://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx

DCHS MHSA Annual Revenue and Expenditure Report Status Update

FY 2005-06 through FY 2018-19, all Counties are current

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Alameda	1/29/2021	2/1/2021	2/8/2021
Alpine			
Amador	1/15/2021	1/15/2021	2/2/2021
Berkeley City	1/13/2021	1/13/2021	1/13/2021
Butte			
Calaveras	1/31/2021	2/1/2021	2/9/2021
Colusa	4/15/2021		
Contra Costa	1/30/2021	2/1/2021	2/22/2021
Del Norte	2/1/2021	2/2/2021	2/17/2021
El Dorado	1/29/2021	1/29/2021	2/4/2021
Fresno	12/29/2020	12/29/2021	1/26/2021
Glenn	2/19/2021	2/24/2021	3/11/2021
Humboldt	4/9/2021		
Imperial	2/1/2021	2/1/2021	2/12/2021
Inyo	4/1/2021		
Kern	2/2/2021	2/2/2021	2/8/2021
Kings	1/4/2021	1/4/2021	3/11/2021
Lake	2/9/2021	2/9/2021	2/17/2021
Lassen	1/25/2021	1/25/2021	1/28/2021
Los Angeles	3/11/2021	3/16/2021	3/30/2021
Madera	3/29/2021	3/30/2021	4/15/2021
Marin	2/2/2021	2/2/2021	2/17/2021

DHCS Status Chart of County RERs Received
May 27, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Mariposa	1/29/2021	1/29/2021	3/11/2021
Mendocino	12/30/2020	1/4/2021	1/20/2021
Merced	1/11/2021	1/12/2021	1/15/2021
Modoc			
Mono	1/29/2021	1/29/2021	2/16/2021
Monterey	2/24/2021	3/1/2021	3/11/2021
Napa	12/23/2020	12/24/2020	12/28/2020
Nevada	1/29/2021	2/16/2021	2/18/2021
Orange	12/31/2020	1/20/2021	2/9/2021
Placer	2/3/2021	2/22/2021	2/23/2021
Plumas	2/25/2021	3/19/2021	3/25/2021
Riverside	2/1/2021	3/31/2021	4/8/2021
Sacramento	1/29/2021	2/1/2021	2/16/2021
San Benito			
San Bernardino	3/3/2021	3/4/2021	3/17/2021
San Diego	1/30/2021	2/1/2021	2/4/2021
San Francisco	1/29/2021	3/19/2021	3/22/2021
San Joaquin	2/1/2021	2/2/2021	2/11/2021
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021
San Mateo	1/29/2021	2/1/2021	2/16/2021
Santa Barbara	12/29/2020	12/30/2020	1/5/2021
Santa Clara	1/28/2021	2/11/2021	3/3/2021
Santa Cruz	3/29/2021	4/5/2021	4/15/2021
Shasta	1/14/2021	1/15/2021	1/19/2021
Sierra	12/31/2020	3/10/2021	4/12/2021
Siskiyou	2/16/2021	2/17/2021	

DHCS Status Chart of County RERs Received
May 27, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Solano	2/1/2021	2/1/2021	2/25/2021
Sonoma	1/29/2021	3/5/2021	4/12/2021
Stanislaus	12/31/2020	1/5/2021	1/5/2021
Sutter-Yuba	1/30/2021	2/1/2021	3/9/2021
Tehama			
Tri-City	1/27/2021	3/4/2021	3/30/2021
Trinity	2/1/2021	2/2/2021	2/17/2021
Tulare	1/26/2021	1/27/2021	2/10/2021
Tuolumne			
Ventura	1/29/2021	2/2/2021	2/16/2021
Yolo	1/28/2021	2/2/2021	2/2/2021
Total	**53**	**50**	**49**

Calendar of Tentative Commission Meeting Agenda Items

Proposed 5/17/2021

Agenda items and meeting locations are subject to change

June 24, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff 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.

July 22, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

OAC Budget Overview
The Commission will consider approval of its Fiscal Year 2020-21 Operations Budget and will hear an update on expenditures.

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

August 26, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Mental Health Student Service Act Update
The Commission will be presented with an update on the implementation of the Mental Health Student Service Act.

Staff Report Out
Staff 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.

September 23, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff 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.

October 28, 2021: Sacramento, CA (Teleconference)

Prevention and Early Intervention Report Presentation
The Commission will consider the final report of the PEI project subcommittee for adoption.

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Workplace Mental Health Report Presentation
The Commission will consider the final report of the WPMH project subcommittee for adoption.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff 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.

November 18, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

INN Subcommittee Year End Report Out

The Commission will be presented with an update on the activities of the Innovation Subcommittee.

Legislative Priorities for 2021

The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out

Staff 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.