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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
June 24, 2021
9:00 AM – 1:30 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 June 24, 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, 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: June 24, 2021

TIME: 9:00 a.m. – 1:30 p.m.

ZOOM ACCESS:

Link: https://zoom.us/j/92881019542
Dial-in Number: 1-408-638-0968
Meeting ID: 928 8101 9542
Passcode: 887109

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 would 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.

9:05 AM **Roll Call**

Roll call will be taken.

9:10 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.

9:40 AM **Action**

1: Approve May 27, 2021 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the May 27, 2021, teleconference meeting.

- Public Comment
- Vote

9:50 AM **Action**

2: Consent Calendar

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

1. Stanislaus County Early Psychosis Learning Healthcare Network Multi-County Collaborative Innovation Plan:
   Approval of $1,564,633 Innovation funding to support joining the Early Psychosis Learning Health Care Network (EP LHCN) approved by the Commission on December 17, 2018.

2. Stanislaus County Full Service Partnership Multi-County Collaborative Innovation Plan:
   Approval of $1,757,146 Innovation funding to support joining the FSP Multi-County Collaborative approved by the Commission on June 5, 2020.

3. Research and Evaluation Contract: Further authorize the Executive Director to enter into one or more contracts not to exceed $4, 244,350 in support of research and evaluation data management and analytical capacity over three years. This authorization extends the Executive Director's authority by $1,222,000 over prior Commission authorizations related to the work effort encompassed by a proposed contract, with the University of California at San Francisco.
   - Public Comment
   - Vote

10:05 AM **Action**

3: Psychiatric Advance Directive Multi-County Collaborative Innovation Project

Presenter:

- **Kiran Sahota, MA, President, Concepts Forward Consulting**

The Commission will consider approval of the following Counties' requests to join the Multi-County Psychiatric Advanced Directive (PAD) Innovation Project in which Fresno County was previously approved by the Commission on June 25, 2019.

Mariposa County	$517,231
Orange County	$12,888,948
Shasta County	$630,731
Monterey County	$1,978,237
Fresno County	$500,000

- Public Comment
- Vote

10:50 AM **Action**

4: Butte County Innovation Plan

Presenter:

- **Danelle Campbell, Program Manager, Prevention Unit, Butte County Behavioral Health**

The Commission will consider augmenting the Physician Committed Innovation Project for an additional two years and $1,252,631 further Innovation spending authority. The augmentation would bring the total authorized Innovation expenditure for this project to $2,484,955 over five years. The original Innovation project was approved by the Commission on May 24, 2018, for $767,900 over three years and on November 14, 2019, the Commission approved an additional $464,424.

- Public Comment
- Vote

11:20 AM **BREAK**

11:30 AM **Action**

5: Merced County Innovation Plan

Presenter:

- **Jeff Sabean, LMFT, Division Director, Merced County Behavioral Health and Recovery Services, Justice and Community Integration Division**

The Commission will consider approval of $3,624,323.39 in Innovation funding for Merced County's Transformational Equity Restart Program Innovation project.

- Public comment
- Vote

12:00 PM **Action**

6: Humboldt County Innovation Plan

Presenter:

- **Jack Breazeal, LMFT, Humboldt County Behavioral Health Services**

The Commission will consider approval of $1,617,598 in Innovation funding for Humboldt County's Resident Engagement and Support Team (REST) Innovation project.

- Public Comment
- Vote

12:30 PM **Action**

7: Imperial County Innovation Plan

Presenter:

- **Brenda Sanchez, MPA, Deputy Director, Imperial County Behavioral Health Services, Youth and Young Adult Services**

The Commission will consider approval of $3,455,605 in Innovation funding for Imperial County's Holistic Outreach Prevention and Engagement (HOPE) Innovation project.

- Public Comment
- Vote

1:00 PM **Action**

8: MHSSA Contract Approval

Presenter:

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

The Commission will consider authorizing staff to allocate funding made available through the budget to support the Mental Health Student Service Act. The Commission will consider fully funding MHSSA applications received in response to the MHSSA grant program, to the extent funding is available.

- Public Comment
- Vote

1:30 PM **Adjournment**

AGENDA ITEM 1

Action

June 24, 2021 Commission Meeting

Approve May 27, 2021 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the May 27, 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) May 27, 2021 Meeting Minutes

Handouts: None.

Proposed Motion: The Commission approves the May 27, 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
May 27, 2021

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

924-8660-3658; Code 806316

Members Participating:

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mayra Alvarez
Ken Berrick
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Steve Carnevale
Shuonan Chen
Itai Danovitch, M.D.
David Gordon
Khatera Tamplen

Members Absent:

John Boyd, Psy.D.
Assembly Member Wendy Carrillo
Gladys Mitchell
Tina Wooton

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

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 reviewed the meeting protocols and gave the announcements as follows:

Announcements

- The next MHSOAC meeting is scheduled for Thursday, June 24th. The agenda will be posted on June 14th. She noted that no Commission meeting is scheduled in July.
- The Commission sponsored the Psychiatric Advance Directives and the Importance of Choice Symposium on May 5, 2021, in partnership with the Saks Institute for Mental Health Law, Policy, and Ethics as part of the Commission's Innovation Incubator work.
- The Commission sponsored a webinar with Solano County around its Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) viewed through a forensic lens as part of a series provided by the Forensic Mental Health Association.
- Through the delegated authority to the Chair, Sonoma County's Innovation Project Nuestra Cultura Cura Innovation Lab and request for up to $736,584 of Innovation funding was approved to increase knowledge and access to underserved or unserved groups. Staff analysis and information on this Innovation Project is included in the meeting materials.
- Through the Commission's development of the Mental Health Services Act (MHSA) Transparency Suite, it has come to the Commission's attention that a number of counties may have reported Innovation expenditures on their 2014-15 through 2016-17 Annual Revenue and Expenditure Reports that did not receive prior Commission approval. Staff is working to identify the issues. The Commission will continue to consider Innovation projects for approval until these items are reconciled.
- On May 13th, the Cultural and Linguistic Competency Committee (CLCC) held their third meeting for 2021. They heard a presentation on the Commission's involvement on the Capitol Collaborative on Race and Equity (CCORE). The meeting included members of the public as well as members of the Client and Family Leadership Committee (CFLC). The goal of the meeting was to gather input from the two Committees and the public on the Commission's Racial Equity Action Plan.
- The Calendar of Tentative Commission Meeting Agenda Items is also included in the meeting materials.

Research and Evaluation Work Update

Commissioner Danovitch provided a brief update of the work of the Research and Evaluation Committee since the last Commission meeting:

- The Committee did outreach and engagement with stakeholders to receive feedback on seven Transparency Dashboards that will soon be released.
- The Commission attained access to two decades of California's birth and death records. This data will be linked with mental health consumer data, which will enable access to mortality rates for a wide range of mental health consumers.

Commissioner Danovitch stated the Research and Evaluation Division has been effectively disseminating the Commission's work in this space. He stated staff took part in a presentation panel at this month's SAS Global Forum. The work of the Research and Evaluation Division was also featured in an online Health IT Analytics article entitled "How Big Data Insights Can Lead to Better Mental Health Care – Using Big Data Collected from Different Public Systems, California's Mental Health Services Oversight and Accountability Commission Delivers Enhanced Mental Health Care."

Commissioner Danovitch stated the next Research and Evaluation Committee meeting is scheduled for June 17th from 1:00 p.m. to 4:00 p.m. The focus of the meeting will be to get feedback on the Mental Health Evaluation Framework for School-Aged Youth.

Roll Call

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

Chair Ashbeck stated Ms. Yeroshek's last day with the Commission is June 4th. She thanked Ms. Yeroshek for her leadership, guidance, and years of service with the Commission and wished her all the best in her new role.

Commissioners and members of the public expressed their thanks, appreciation, and gratitude for Ms. Yeroshek and her work over the years.

GENERAL PUBLIC COMMENT

Mary Ann Bernard, lawyer, family member, and advocate for the severely mentally ill, stated the severely mentally ill is the group the MHSA was adopted by the voters to help. The speaker stated advocates gave up on this Commission years ago when only one Commissioner seemed interested in helping the individuals the MHSA was enacted to help.

Mary Ann Bernard stated they sent letters to Commissioners reminding them that, when rethinking prevention and early intervention, the MHSA states the Commission "shall" also include components similar to programs that have been successful in reducing the duration of severe mental illness and assisting individuals in quickly regaining productive lives. Prevention and early intervention include relapse prevention and early intervention in relapses for individuals who are already severely mentally ill.

Mary Ann Bernard stated this mandate can be easily complied with by sending prevention and early intervention funds to two vital programs that are already in MHSA Section 5813.5(f). The speaker stated putting individuals who are severely mentally ill in jail is costly, cruel, and dangerous to them and the public. The speaker asked that prevention and early intervention funding be used for relapse prevention and early intervention programs for individuals who already have severe mental illness.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), respectfully requested that the Commission form a Legislative Committee. The speaker asked what the decisions on bills to consider are based upon. Also, the legislative priorities to be voted on later in the agenda include Senate Bill (SB) 465, but the County Behavioral Health Directors Association (CBHDA) that opposes the bill was not invited to present and will only have the opportunity to speak during public comment. The Commission should hear public comment on which bills to vote upon and why and should hear both sides of the bills.

Poshi Walker, LGBTQ Program Director, Cal Voices, echoed Stacie Hiramoto's request for a Legislative Committee. The speaker stated it will be helpful for Commissioners, a venue for valuable discussion, and a more informed vote on legislative issues.

Poshi Walker suggested thinking about future meetings now that most individuals are vaccinated. In the past, individuals who were unable to be in attendance in person could only listen in and not fully participate in meaningful ways. The speaker stated their preference for in-person meetings; however, the speaker stated Zoom has allowed stakeholders to attend and participate in ways that were not possible before. The speaker suggested considering a hybrid model when returning to in-person meetings that would allow individuals to attend from across the state in a meaningful way.

Poshi Walker respectfully asked that everyone use strength-based language when speaking about mental health and mental illness. People are not schizophrenic or mentally ill, they are individuals living with schizophrenia, mental illness, or mental health challenges. People are human beings with other aspects to their lives.

Rachel Mino, Senior Attorney, Law Foundation of Silicon Valley, expressed strong support for the Independent Living Empowerment Project and encouraged the Commission to approve the proposal to invest MHSA funds for the development, staffing, and implementation of the program.

Steve McNally, family member, thanked Ms. Yeroshek for setting an expectation in understanding.

Steve McNally asked about Assembly Bill (AB) 1331 to support a statewide director of crisis services. While they are not against having someone in that role, the speaker asked why it is necessary in California for legislation to mandate that there be local implementation of a Substance Abuse and Mental Health Services Administration (SAMHSA) toolkit. The speaker stated it is worrisome how far the state has gone away from local implementation of mental health funds in the state.

Steve McNally stated the 17th Annual Evening with the Stars, hosted by the San Bernardino County Behavioral Health Commission, will be held tomorrow night. It proves that counties can do more to raise the focus of mental health.

Steve McNally stated Riverside County has done an MHSA advertising campaign on Facebook where approximately 3,000 individuals attended their 40-minute video. It is difficult for communities to know what is going on through the filters. The speaker asked Commissioners to close the loop at the local level.

Lorraine Zeller, MHSA Steering Committee, County of Santa Clara; Coordinator, Community Living Coalition, spoke in support of the Independent Living Empowerment Project, which is on page 211 of the meeting materials. The speaker asked for the Commission's approval of the project.

Uday Kapoor, Board of Directors, National Alliance on Mental Illness (NAMI), Santa Clara County, spoke in support of the Independent Living Empowerment Project. The speaker asked for the Commission's approval of the project.

Elisa Koff-Ginsborg, Executive Director, Behavioral Health Contractors Association, spoke in support of the Independent Living Empowerment Project. The speaker asked for the Commission's approval of the project.

Mark Karmatz, consumer and advocate, stated there will be a meeting on certified peer specialists at 2:00 p.m. today in Los Angeles, hosted by the CBHDA. The speaker stated concern that stakeholders were not involved in those meetings. The speaker asked for additional information on AB 465 and AB 1331.

Jennifer Jones, Consumer Affairs Program Manager, Santa Clara County, and member of the MHSOAC CFLC, spoke in support of the Independent Living Empowerment Project. The speaker asked for the Commission's approval of the project. The speaker shared that they are changing positions to the Mobile Crisis Response Team next week.

Kathy Forward, NAMI Santa Clara County, spoke in support of the Independent Living Empowerment Project. The speaker asked for the Commission's approval of the project.

ACTION

1: <u>Approve April 22, 2021, MHSOAC Meeting Minutes</u>

Chair Ashbeck stated the Commission will consider approval of the minutes from the April 22, 2021, teleconference meeting.

Public Comment

No public comment.

Commissioner Questions and Discussion

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

Commissioner Berrick made a motion to approve the April 22, 2021, teleconference meeting minutes.

Commissioner Danovitch seconded.

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

- *The Commission approves the April 22, 2021, Teleconference Meeting Minutes as presented.*

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

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Carnevale, Chen, Danovitch, and Gordon, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

The following Commissioners abstained: Commissioners Bunch and Tamplen.

ACTION

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

Presenter:

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

Commissioner Berrick recused himself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Ashbeck stated the Commission will consider approval of $3,080,986 in Innovation funding for Ventura County's Mobile Mental Health Innovation Project. She asked the county representative to present this agenda item.

Hilary Carson, MSW, Senior MHSA Program Administrator, Ventura County Behavioral Health, provided an overview, with a slide presentation, of the need, proposed project to address the need, community planning process, and budget of the proposed Mobile Mental Health Innovation Project.

Commissioner Questions

Commissioner Bunch asked if the proposed Innovation Project will be a step-down for clients coming off of 5150s and psychiatric holds or if that is a future goal.

Ms. Carson stated clients would not necessarily come down from a 5150, if they were able to get treatment. It is more for individuals who were attempting to get hospitalized or in a hold in an emergency room and nothing opened up for them. She stated it is meant to be a support similar to a follow-up appointment.

Commissioner Bunch asked if the mobile team will also transport, if there is a need for a 5150 while out in the field,

Ms. Carson stated it is still to be determined. She stated the mobile team will have the ability to transport, but that is not their primary focus. The county also has a crisis team and a Rapid Integrated Support and Engagement (RISE) team that can assist in transportation. She stated it will depend on the contractor and what makes the most sense.

Commissioner Bunch asked for additional detail on the culturally responsive mental health services.

Ms. Carson stated the county does a wide variety of cultural competency trainings, but the literature review showed that these might not be enough. The staff needs to feel comfortable not only engaging but outreaching to individuals who may be different from them and to make everyone feel welcome. This may be done in a variety of ways such as engaging with partner organizations, doing well-documented trainings, and working with the Request for Proposals (RFP) awardees.

Vice Chair Madrigal-Weiss asked about the engagement of youth, if information was gathered from homeless youth, and if there was a connection with the county office of education and homeless liaison projects. She stated there has been a rise in substance use in youth. She asked about planning around that.

Ms. Carson stated the county education department is working closely with the school homeless outreach liaison. The locations of focus have yet to be determined. She stated the county will be working with the RFP recipients for the first year to determine other county entities where there may be the most interest and greatest need and also areas where the program does not need to be consistent but is still important to engage with those communities.

Commissioner Danovitch stated the presentation materials can make a stronger case for what specifically is innovative about this project versus other similar programs that have been implemented. He stated the presenter mentioned that the plan is yet to be determined; yet, the plan around sustainability is critical, especially with the high likelihood that it will be effective.

Commissioner Danovitch stated the evaluation plan must address what key stakeholders and the county need to know to make decisions to continue to support this project over time, if it is effective. Otherwise, what is needed in order to sustain it may not be learned. This is critical to address prior to launching the proposed project.

Commissioner Danovitch stated part of the interest in this project was individuals waiting in the emergency department until their holds expire, but none of the evaluation metrics looked at holds, emergency department utilization, or emergency department boardings. He suggested measuring that if the expectation is that this project will influence that. He stated he would only vote to approve this plan if the sustainability factors were specified and the evaluation would answer necessary questions so, if successful, the proposed project could be sustained over time.

Ms. Carson stated staff also brought up some of Commissioner Danovitch’s concerns. She stated the county has been thinking about those issues. For sustainability, she stated the county has a commitment from her department to continue funding the project and has tentative commitments from partner agencies. For evaluation, the county is hoping to track some of Commissioner Danovitch’s suggestions. She noted that much of that data belongs to partner agencies rather than to Ventura County Behavioral Health, so the county did not want to commit to that in the evaluation not knowing if they will be given access to that data.

Commissioner Danovitch stated the County Counsel in Los Angeles County has determined that the clock for holds does not begin until individuals enter Lanterman Petris Short (LPS) facilities. This makes the proposed project more pressing, but it means that individuals at high risk do not have to be released from emergency departments when their holds expire because their hold time has not yet begun. He stated that may be worth exploring with Ventura County's legal department.

Chair Ashbeck stated County Counsels interpret that law differently across the state. She echoed Commissioner Danovitch's comments. She stated the hope that the county will be given access to that data from the partner agencies. She suggested more specificity on that data.

Chair Ashbeck stated, in the evaluation metrics, nothing is measured on the human level outcome such as the frequency of returning to the emergency department or the variation of time spent in the emergency department. Human and system outcomes are important to measure and will help make the case for sustainability with partners.

Commissioner Carnevale agreed with Commissioner Danovitch and Chair Ashbeck. He stated the proposed project seems like an essential service to be provided, but he stated the need to better understand other areas of the state where this is being done, if it has been modeled after anything, or if it is innovative. If innovative, it is essential that the results be measured because, if successful, it should be rolled out across the state as quickly and effectively as possible.

Ms. Carson stated seven other counties were doing some kind of mobile mental health project – some were more focused on prevention services while others were focused on specific communities. She stated the component that set Ventura County apart is the partnership with the health care agency to enable ongoing measurements for some of the comorbidities that take place for individuals diagnosed with a serious mental illness. She noted that the county modeled some of the proposed project from the nationwide literature.

Ms. Carson stated the county is open to adding or revising questions on the evaluation plan. The RFP is not yet written. She stated the hope that she is not underplaying the county's confidence in getting some of the data because they have the advantage of the Full-Service Partnership (FSP) data exchange. Some of this is already set to happen within eight months to a year. She stated it would not be difficult to ask for broader data sets than the FSP data.

Commissioner Gordon asked what has been done to build receptivity to the utilization of a van in the communities that are most difficult to serve. He stated reluctance to come into a brick-and-mortar facility may be no different with a van, unless something is done in the community to let them know it provides a culturally competent approach to service.

Ms. Carson stated the mobile team will need to consistently build relationships and dependability in the community. The county is working with and leveraging entities that are already working successfully with these populations to build awareness of the mobile unit's approach, capabilities, and scheduling.

Chair Ashbeck suggested reaching out to Fresno County to learn about their central service sections and their mobile unit, based at the back of a food truck.

Public Comment

Poshi Walker stated the presenter used the term “cultural adeptness” in the presentation to make the people feel welcome and the staff feel comfortable with the clients they are servicing. The speaker cautioned that, especially for the LGBTQ community and other racial and ethnic groups, having a staff member feel comfortable does not necessarily equal competent care. Also, when someone thinks they are being welcoming, oftentimes it looks like “I accept you,” but that kind of language is not enough and still sends the message that there is something wrong with the person that needs to be accepted.

Poshi Walker stated, when someone is in crisis, especially if they are in crisis because of rejection and discrimination for being LGBTQ, it is vitally important that they are not additionally harmed or that their needs are misunderstood or ignored because the person serving them does not understand. The speaker recommended contracting with LGBTQ agencies or providers in the area to do responses to LGBTQ individuals. Also, there may be other cultural and linguistic issues going on.

Poshi Walker cautioned not to expect one person to be competent in all the letters of the LGBTQ acronym.

Mark Karmatz asked if the proposed project will include certified peer specialists.

Ms. Carson stated the project includes certified peer specialists but it is up to the contractor to determine the number.

Commissioner Discussion

Chair Ashbeck asked for a motion to approve Ventura County’s Mobile Mental Health Innovation Project.

Commissioner Danovitch moved the staff recommendation, with a strong recommendation to establish an evaluation plan that addresses the sustainability factors that are identified in the analysis.

Vice Chair Madrigal-Weiss seconded.

Commissioner Bunch offered a friendly amendment to request that staff work with the county.

Commissioner Danovitch agreed that staff should be available to support the process but stated the county should decide where to look for that assistance. He rejected the friendly amendment.

Chair Ashbeck stated the original motion stands with the understanding that staff will be a potential resource to the county.

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

The Commission approves Ventura County's Innovation Plan with a strong recommendation to establish an evaluation plan that addresses the sustainability factors that are identified in the analysis, as follows:

Name: Mobile Mental Health

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

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Bunch, Carnevale, Chen, Danovitch, Gordon, and Tamplen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

Commissioner Berrick rejoined the meeting.

ACTION

3: <u>Los Angeles County – Trieste (aka Hollywood 2.0) Innovation Project</u>

Presenter:

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

Commissioner Bunch recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Ashbeck stated the Commission approved Los Angeles County's Trieste (aka Hollywood 2.0) Innovation Project for five years with an Innovation budget of up to $116,750,000 on May 23, 2019. At that time, the county proposed to fund the Trieste Project solely with Innovation funds to allow for maximum flexibility to create a comprehensive recovery-informed mental health system funded 100 percent with MHSA Innovation funds.

Chair Ashbeck stated, according to the Los Angeles County letter dated April 13th, which is included in the meeting materials, the county indicates that due to the COVID-19 pandemic, they had to shift their priorities based upon the direction of the board of supervisors, the needs of their clients, and the needs of the new clients who have emerged because of the pandemic. Los Angeles County is now requesting to leverage Medi-Cal drawdown as a funding source for the Trieste Project, instead of solely funding the project with Innovation dollars.

Chair Ashbeck directed Commissioners' attention to the staff report, included in the meeting materials, which included possible questions to guide the discussion. She asked the county representative to present this agenda item.

Jonathan E. Sherin, M.D., Ph.D., Director of Mental Health, Los Angeles County, provided an update on the project, reviewed what has remained unchanged, and listed the proposed changes to the project necessitated by the fiscal challenges and

uncertainties of the COVID-19 pandemic, as outlined in his letter of April 13th, the staff report, and the project summary, which were included in the meeting materials.

Commissioner Questions

Commissioner Berrick stated he was one of the individuals who was concerned about the original plan leaving the federal match on the table. He stated, although he understood why the county made that choice, he was thrilled to see the county moving in this direction and hoped it will be instructive for the whole state on how to do this. He encouraged the county to take the opportunity to document the barriers that are created by the current funding system to help inform how this is transformative. He stated the hope that the changes made to the program will not change the texture and nature of the original intent.

Chair Ashbeck stated this Innovation Plan started in 2019. She asked about the current timeline of the plan.

Dr. Sherin stated the county has been working on many things in order to launch the program with the hope of moving the project forward by July of this year, and, even with the COVID-19 pandemic, that is still a possibility. He stated the hope to begin identifying and committing to various types of housing, expanding FSP, looking for peer respite sites, and engaging property owners by July 1st of this year.

Commissioner Tamplen asked if service providers will still receive training on how to use recovery-focused, whole person approaches to care while complying with documentation requirements.

Dr. Sherin stated the county developed a powerful and safety-net-oriented partnership with UCLA called the Public Partnership for Wellbeing, which is a massive training component that focuses on FSP work. It is a significant sophisticated training capacity that will be focused on this project as needs arise.

Commissioner Tamplen asked how the removal of technology development and changes resulting from the COVID-19 pandemic have changed the timeline and budget.

Dr. Sherin stated the changes expedite the program. The budget should not be decreased – the homeless population has grown during the COVID-19 pandemic, which may require a significant increase in the number of FSP teams and the amount of housing.

Public Comment

Elan Shultz, Senior Health Deputy, Office of Supervisor Sheila Kuehl, who represents the Hollywood area as well as much of the Northern and Western City of Los Angeles and the San Fernando Valley, spoke in support of the proposed changes to the Trieste Innovation Project.

Samuel Liu, Deputy Chief of Staff, Office of State Senator Ben Allen, who represents the West side, Coastal South Bay, and Hollywood Region in the State Legislature, spoke in support of the proposed changes to the Trieste Innovation Project.

Aditi Shakkarwar, Field Representative, Office of Assemblymember Richard Bloom, who represents the assembly districts, which includes Hollywood, spoke in support of the proposed changes to the Trieste Innovation Project.

Andrea Conant, Deputy Chief of Staff and District Director, Los Angeles City Councilmember Mithai Ramen, spoke in support of the proposed changes to the Trieste Innovation Project.

Sean Starkey, Los Angeles City Councilmember Mitch O'Ferrell, who represents the 13th district, which includes the Hollywood entertainment district and much of Hollywood's residential area, spoke in support of the proposed changes to the Trieste Innovation Project.

Maggie Merritt, Executive Director, Steinberg Institute, spoke in support of the proposed changes to the Trieste Innovation Project.

Steve Leoni, consumer and advocate, spoke in opposition to the proposed changes to the Trieste Innovation Project. The speaker stated changes remove a major part of what the original process was about. California Advancing and Innovating Medi-Cal (CalAIM) does not change the fact that billing for Medi-Cal must address illness, not recovery. The question about how a treatment will help a person recover is never asked; instead, the question is how it addresses symptoms or illness. This has tripped up the MHSA since the beginning. The speaker stated, by eliminating three of the five system changes in the original project, including a recovery-informed reimbursement system and recovery-informed documentation, major parts of the intended freedoms are lost.

Steve Leoni stated the project was meant to be cost-neutral and without a federal drawdown. The speaker requested reconsidering the amount of MHSA funding given for this project, now that a federal drawdown is required. The speaker stated nothing will be demonstrated without a cost-neutral demonstration project except that throwing millions of dollars at something might fix it. That is not what Innovation funding is for.

Steve Leoni was skeptical about the homeless issue. The speaker stated the bottom line is that there is not enough housing to go around and individuals who are poor get caught up in that, including individuals with mental illness. Continuing to support people in housing drains funding. Los Angeles is currently under court order to get the homeless off the street. The speaker stated it would be very upsetting to drain mental health funds for this purpose. That is not what the Commission should be doing.

Mark Karmatz stated Los Angeles County has a serious homeless issue. The speaker suggested listening to Doors to Wellbeing workshops.

Commissioner Discussion

Chair Ashbeck stated the fundamental change request is to change the Innovation funding model to eliminate the recovery-informed reimbursement system to rely on Medi-Cal. She stated concern was stated during public comment that this conceptually changes how the original project was framed. She agreed with Dr. Sherin that the Commission would like to hear regular updates on how the project is rolling out and how the changes might adjust the overall budget or expenditure plan.

Chair Ashbeck asked for a motion to approve the proposed changes to the project.

Commissioner Berrick moved to approve the proposed changes.

Commissioner Danovitch seconded.

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

The Commission approves Los Angeles County's request to change the reimbursement system that was in the original Trieste Innovation project plan and requests the County provide updates to the Commission every six months.

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

The following Commissioners voted "Yes": Commissioners Berrick, Brown, Carnevale, Chen, Danovitch, Gordon, and Tamplen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

Commissioner Bunch rejoined the meeting.

BREAK

ACTION

4: <u>Santa Clara County Innovation Plan</u>

Presenter:

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

Chair Ashbeck stated the Commission will consider approval of $27,949,227 in Innovation funding for Santa Clara County's Community Mobile Response (CMR) Program Innovation Project. She asked the county representative to present this agenda item.

Jeanne Moral, Program Manager III, County of Santa Clara Behavioral Health Services, Systems Initiatives, Planning and Communication, provided an overview, with a slide presentation, of the need, proposed project to address the need, community planning process, and budget of the proposed Community Mobile Response Program Innovation Project.

Commissioner Questions

Commissioner Bunch asked how this plan is innovative and differs from other counties' mobile crisis teams.

Ms. Moral referred to Presentation Slide 3, CMR Planning and Community Input, and reviewed the proposed program's five innovative approaches: family involvement, prevention focused, access through a trusted community phoneline, transformed trauma informed mobile response vehicle, and community collaborators and highlighted

innovative components. She noted that the county is adapting the Crisis Assistance Helping Out on the Streets (CAHOOTS) model from Eugene, Oregon.

Chair Ashbeck stated there are several mobile service Innovation plans throughout the counties. She asked staff to incorporate comparisons of similar Innovation plans into the staff analysis or the county reports.

Chair Ashbeck asked if the project will use 9-1-1 for intake.

Ms. Moral stated a separate three-digit number will be assigned that is not associated with government or public safety.

Commissioner Brown asked how calls will be triaged and teams dispatched, how the county will make the determination who responds to a mental health crisis, and how to ensure that the mobile team will be protected in circumstances with the potential for violence or the use of violence if the call is made to 9-1-1.

Ms. Moral stated both the call center and onsite field service teams will be operated by a community-based organization that will be tasked with building out the triage and workflow shown in the presentation slides in terms of safety. They will also be tasked with communicating with and educating the public safety partners on how to patch through a call to the CMR.

Commissioner Brown stated Santa Clara County would essentially have three different types of teams to respond to crisis calls in the field. Each team will be equipped and staffed differently. There is a potential for an incorrect response to occur when the wrong team is dispatched to the wrong call. He stated concern of the county's potential to be put in a position of not having the properly trained and equipped team at a particular type of call, such as when someone is causing a disturbance. He cautioned against being put in a position where the safety of the callers and responders are put in jeopardy in this effort to eliminate law enforcement from the equation.

Public Comment

Sparky Harlan, CEO, Bill Wilson Center, spoke in support of the proposed project.

Elise Koff-Ginsborg, Executive Director, Behavioral Health Contractors Association, spoke in support of the proposed project.

Adrienne Shilton, Senior Policy Advocate, California Alliance of Child and Family Services, spoke in support of the proposed project.

Don Taylor, Executive Director, Uplift Family Services, spoke in support of the proposed project.

Mary Glomer, CEO, Project Safety Net, spoke in support of the proposed project.

Poshi Walker thanked the county for mentioning family of choice for LGBTQ individuals. The speaker suggested looking at the Family Acceptance Project interventions, especially for youth, so that families who are maybe causing problems can come together.

Poshi Walker stated concern that this project is being questioned as not being innovative. The Commission is not consistent not only with how Innovation is defined,

but when it is or is not held up as a criteria. The speaker stated they would much rather see a project like this funded than the funding be reverted and put toward CSS, for example.

Poshi Walker stated LGBTQ individuals are also afraid of contacting law enforcement. The speaker responded to Commissioner Brown's question about responding to a situation where someone is causing a disturbance by asking why there is an assumption that the police presence would deescalate a situation more than someone who has been trained to work with individuals who are escalating. Evidence shows that in many or most cases police presence does not deescalate the situation but often escalates it. Currently, there are many instances of the police being the incorrect response. In response to the concern about calling the wrong team, the speaker stated there often is only one team to call and that police response often is the wrong choice.

Poshi Walker stated understanding that changing the scope of work for the police, especially for individuals who are involved as part of their career, feels difficult and different but this does not mean that it is wrong. The speaker stated it is incredibly innovative to say that not only is it important for the safety of the community that clinicians are protected, but that the individuals being responded to are protected. The speaker stated it is questionable for law enforcement to be sent for any mental health issue.

Yvonne Maxwell, Executive Director, Ujima Adult and Family Services, stated the plan is for the response team to be highly trained, know how to bring resolution, and be embedded in the community. The speaker spoke in support of the proposed project.

Tarob Ansari, resident, stated many consumers considered the therapeutic transport as the most innovative aspect of this project. The only current transport options are ambulance or police cruisers. The speaker stated research done by the California Reducing Disparities Project (CRDP) shows that individuals can be retraumatized by being placed in handcuffs or being transported in police cruisers or other marked vehicles. Having a therapeutic venue where individuals can relax and deescalate is possibly the most important part of this project. The speaker spoke in support of the proposed project.

Commissioner Discussion

Chair Ashbeck stated police reform is driving this kind of response in possibly every county. She asked Commissioner Brown about the trend being seen and what the Commission can do to get ahead of that trend to either align, inventory, or streamline these types of requests.

Commissioner Brown stated the trend is to do things differently from the way they have historically been done. As with most programs and initiatives, there is not a one-size-fits-all model. He stated his county has a co-response program that incorporates some of the elements of the proposed project, such as responses in unmarked vehicles, pairing of a law enforcement officer with a clinician, or law enforcement wearing a soft-type nonstandard uniform. And most of the time when transport is necessitated, it is done in an unmarked vehicle. He recognized that this program acknowledges the

stigma when someone is restrained and put into an ambulance or police vehicle and taken to a hospital. The proposed program is innovative and has a good approach.

Commissioner Brown stated this program most often will work just fine. The program's variation of the CAHOOTS model is being offered as an alternative to the traditional response where there is no team versus mobile response, where there is a team of mental health professionals who do not have a partnership with local law enforcement or with consumers or peers who are involved in it. The question is if it is appropriate for the community. The idea that there is some over-the-phone interaction, which may alleviate the need for a response, is commendable. The provided material was vague about how the decision is made to either refer the call to one of the different teams or law enforcement for response. There is a wide range of variables.

Commissioner Brown cautioned that there are instances that can be very violent and very lethal. A co-response model strikes an appropriate and good balance between the different options and works well in his county. It is important that safety be considered when certain indicators are present. There should not be a hesitancy either on the part of the public or mental health professionals to call law enforcement if those dangers are indicated.

Commissioner Brown stated concern about the composition of the mobile team's lack of a clinician or licensed personnel. He stated this program is innovative and has not been seen before in any other program.

Commissioner Bunch agreed with public comment that the Commission has been inconsistent in what constitutes Innovation. She stated there is a difference between Innovation and need. She stated the need for a larger discussion about what it means to be innovative.

Commissioner Tamplen stated another way this program is innovative is that it is available 24 hours, 7 days a week, 365 days a year.

Commissioner Tamplen stated great ideas come to the Commission and get funded as an Innovation. Other counties become aware of it and want part of that too, but it is no longer innovative; yet, in some situations, the Commission has opened it up for other counties to join in. There is an opportunity for that in this case because it is innovative in terms of how practice is done in responding to individuals who are in crisis. It is important to hear what communities are saying.

Commissioner Tamplen stated she does not see law enforcement being excluded. When law enforcement is required, they will engage.

Chair Ashbeck asked for a motion to approve Santa Clara County's Mobile Response Program Innovation Project.

Commissioner Tamplen moved to approve the proposed project.

Commissioner Bunch seconded.

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

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: 4.5 Years (4 yrs, 6 months)

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

The following Commissioners voted "Yes": Commissioners Berrick, Brown, Bunch, Carnevale, Chen, Gordon, and Tamplen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

ACTION

5: Marin County Innovation Plan

Presenter:

- Taffy Lavie, Administrative Assistant II, County of Marin, Department of Health and Human Services, Behavioral Health and Recovery Services Division

Chair Ashbeck stated the Commission will consider approval of $1,795,000 in Innovation funding for Marin County's From Housing to Healing, a Re-Entry Community for Women Innovation Project. She asked the county representative to present this agenda item.

Taffy Lavie, Administrative Assistant II, County of Marin, Department of Health and Human Services, Behavioral Health and Recovery Services Division, provided an overview, with a slide presentation, of the need, proposed project to address the need, community planning process, and budget of the proposed From Housing to Healing, a Re-Entry Community for Women Innovation Project.

Commissioner Questions

Commissioner Carnevale stated UCSF has been doing innovative work in collaboration with Hastings Law School around incarceration, particularly the women's population at the Dublin Women's Prison. The study, which will soon be released, supports much of what this presentation is about in hard neuroscience evidence. He suggested connecting offline with the county to discuss possible cross-connections.

Commissioner Brown stated it is refreshing to see a truly innovative project and to see a project presented well by an individual who is heavily invested in this cause. He saluted Ms. Lavie for sharing her story of recovery. He stated the sheriff's office in Santa Barbara County is blessed with a person similar to Ms. Lavie, who has gone through the system and is in charge of the sheriff's treatment program. He stated he would be happy to introduce them as they are doing many of the same things in the jail in Santa Barbara that Ms. Lavie is doing in Marin County. He stated appreciation and gratitude for the work Ms. Lavie is doing in Marin County and wished her luck with the proposed project.

Vice Chair Madrigal-Weiss stated she looked forward to what will be learned with the proposed project, since the way things have historically been done does not produce the best outcomes. She suggested taking the learnings from this program to the juvenile centers in order to get ahead of this. She stated appreciation that the program looks beyond medications but speaks to the whole person to address the trauma and to address it earlier and holistically. She thanked Ms. Lavie for sharing her story, being authentic, and speaking to that whole person and human experience. These are the necessary conversations in order to address the problems that are needed to be addressed.

Commissioner Bunch echoed the previous Commissioners and agreed with doing this on a larger scale and bringing it down to juvenile centers.

Chair Ashbeck asked about the number of individuals who will be served with the proposed program.

Michelle Funez Arteaga, Jail Mental Health Supervisor, stated there are six beds in the house, one of which will be a peer provider who has been through some of these issues and can provide support and mentorship. Part of the Innovation of this house is that the individuals will not be asked to leave or discharged in an arbitrary timeline to allow time for a solid transition. Although she was unable to predict the length of time individuals will stay, she stated next steps for the individual will be part of the discussion from the beginning. She stated the average timeline to help individuals find the next safe place will be part of the learning.

Public Comment

Adrienne Shilton spoke in support of the proposed project.

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, asked how the children of these women will be incorporated into the program. These children are often also survivors of trauma and have high adverse childhood experiences (ACEs) scores.

Ms. Funez Arteaga stated there is not an element to include children in this program. These women oftentimes are in active crisis and are facing a huge variety of challenges. She stated the women this project will serve do not currently have custody of their children or may need to get on a path to being able to care for their children. She stated there is at least one recovery house for women in Marin County who can have their children with them, but it does not address trauma or is not geared for individuals who are in active crisis.

Ms. Funez Arteaga stated including children would create a different focus. The goal to support the women in reunification or getting back with their children will definitely be an aspect of this program.

Andrea Crook, Director of Advocacy, ACCESS California, a program of Cal Voices, stated there is one FTE for one trauma therapist, who will be employed by the county, and the rest of the staff will be contracted through a community-based organization. The speaker asked about the staffing structure and about wages for peer employees.

Maggie Merritt spoke in support of the proposed project.

Poshi Walker suggested that the program also take care of the children – not necessarily in the house, but perhaps with counseling either separately or with their mothers.

Poshi Walker stated the hope that the program is successful. The speaker suggested looking at a more upstream solution to consider what would happen if, instead of taking these women out of jail, they instead were diverted from ever going into the jail.

Commissioner Discussion

Chair Ashbeck asked for a motion to approve Marin County's From Housing to Healing, a Re-Entry Community for Women Innovation Project.

Commissioner Brown moved to approve the proposed project.

Commissioner Carnevale seconded.

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

The Commission approves Marin County's Innovation Plan, as follows:

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

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

Project Length: Five (5) Years

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

The following Commissioners voted "Yes": Commissioners Berrick, Brown, Bunch, Carnevale, Chen, Gordon, and Tamplen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

ACTION

6: <u>Legislative Priorities for 2021</u>

Presenters:

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

Chair Ashbeck stated the Commission will consider legislative and budget priorities for the current legislative session including Senate Bill (SB) 465 (Eggman) and the Governor's May Revise. She invited Mr. Stammerjohan to give his presentation on SB 465.

David Stammerjohan, Chief of Staff, Office of Senator Eggman, stated Senator Eggman's office came into this year with an intentional focus on the many of the most pressing needs in the lives of Californians – access to health care, mental health care, food security, and housing. He stated Full Service Partnerships (FSPs) lie at the

intersection of these needs. FSPs are intended to reach those with the greatest needs in the community. He stated SB 465 was crafted with technical assistance from the Commission to review how FSPs are serving those individuals and how they might be improved to better prevent homelessness, hospitalization, and incarceration.

Mr. Stammerjohan stated SB 465 specifically requires the Commission to report to the Legislature on how many of those served by FSPs experience these outcomes, why individuals separate from FSPs, the services they receive, and outcomes. The report is also to include the degree to which those with the greatest needs are accessing these services, barriers to the Commission's access to relevant data, and recommendations for strengthening these programs.

Mr. Stammerjohan stated SB 465 focuses on understanding how the most the significant portion of the mental health services fund are meeting the needs of those they target, and hopes to build on the work of counties that have taken the lead in starting to evaluate how a more outcomes-oriented approach could improve care. He asked for the Commission's support of SB 465.

Public Comment

Elissa Feld, Senior Policy Analyst, CBHDA, stated the CBHDA continues to look favorably on the FSP language. The speaker stated, as this bill moves forward, members have asked to include the Department of Health Care Services (DHCS) as one of the stakeholders in discussing this information, including the data challenges. The FSP data is reported to the DHCS and they have an important role in this discussion.

Elissa Feld stated the CBHDA believes that county behavioral health agencies should be explicitly named as one of the subject matter experts in this bill. Some of the members are also part of the Commission-led learning collaborative to evaluate FSPs and make recommendations on improvements and were interested in learning how the Commission sees this effort aligning with SB 465.

Elissa Feld stated the CBHDA plans to continue to engage with the author's office and the sponsors and thanks the Commissioners and staff for their continued collaboration on this bill.

Randall Hagar, Psychiatric Physicians Alliance of California, sponsor of SB 465, stated this is a significant program and is at the core of what many counties do. The speaker stated this bill looks to gather data so the data can be more effectively used and targeted to produce better outcomes and have more fidelity to the model upon which it is based. An investment in data can have a payoff in more appropriate treatment for those who are experiencing some of the more severe crises in the state due to their mental health.

Poshi Walker stated a comment was made at the beginning of this meeting that it would be helpful, when a bill or budget item is brought before the Commission and the public, for both sides to be invited to discuss it. It is concerning for only one side of an issue to be presented when the Commission is being asked to give their support. The speaker asked how Commissioners can make an educated decision and choice when only

hearing the supporters and not any arguments against. The speaker stated this is another opportunity where a Legislative Committee would have been helpful to bring the Commission the full information.

Commissioner Questions and Discussion

Commissioner Berrick asked if there is formal opposition to the bill.

Mr. Hagar stated the organization that has expressed concerns is the CBHDA. The author's office has been very happy to work with them towards common agreement on the bill. The speaker stated they look forward to continuing to do that.

Mr. Stammerjohan stated there is no formal opposition at this time.

Commissioner Tamplen asked for the author's and sponsor's thoughts on CBHDA's requests outlined in Elissa Feld's public comment.

Mr. Hagar stated the sponsor has no problem writing those entities into the bill. Anyone who has a voice and stake in the process should be involved.

Mr. Stammerjohan stated the author's office is happy to have that conversation. He noted that one of the challenges with adding names is that someone inevitably is left out.

Chair Ashbeck asked for a motion to support SB 465.

Commissioner Berrick moved to support SB 465.

Commissioner Carnevale seconded.

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

The MHSOAC supports SB 465.

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

The following Commissioners voted "Yes": Commissioners Berrick, Brown, Bunch, Carnevale, and Chen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

The following Commissioners abstained: Commissioners Danovitch and Tamplen.

ADJOURNMENT

There being no further business, the meeting was adjourned at 1:26 p.m.

AGENDA ITEM 2

Action

June 24, 2021 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission will consider for approval three items placed on the Consent Calendar: Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Any item may be pulled from the Consent Calendar at the request of any Commissioner.

Consent Calendar Items shall be considered after public comment, without presentation or discussion. Items removed from the Consent Calendar may be held over for consideration at a future meeting at the discretion of the Chair.

1. Stanislaus County request to join the Commission approved Early Psychosis Learning Health Care Network Multi-County Collaborative and expend up to $1,564,623 in Mental Health Services Act Innovation funds over five years.
2. Stanislaus County request to join the Commission approved Full-Service Partnership Multi-County Collaborative and expend up to $1,757,146 in Mental Health Services Act Innovation funds over four and a half (4.5) years.
3. Authorization for the Executive Director to enter into one or more contracts not to exceed $4,244,350 in support of research and evaluation data management and analytical capacity over three years. This authorization extends the Executive Director's authority by $1,222,000 over prior Commission authorizations related to the work effort encompassed by a proposed contract with the University of California at San Francisco.

1. Early Psychosis Learning Health Care Network Multi County Collaborative

In December 2018, the Commission approved the Early Psychosis Learning Health Care Network multi-county collaborative to improve outcomes for participants in Early Psychosis programs, while also reducing costs.

Currently, 24 of the 59 counties in California have Early Psychosis programs, but there is a lack of standardization and infrastructure to properly evaluate evidence-based practice and effectiveness of these programs.

To increase effective engagement and treatment approaches to decrease the duration of untreated psychosis and maximize early detection of psychosis symptoms, Los Angeles, Orange, San Diego, Solano, and Napa Counties were approved, by the Commission to contract with UC Davis Behavioral Health Center of

Excellence (the Contractor) to lead the project with support from One Mind and partnerships with UC San Francisco, UC San Diego, and the University of Calgary.

Stanislaus County is requesting up to $1,564,633 of Innovation spending authority to join the Learning Health Care Network.

By joining the LHCN, Stanislaus County adds value to the learning collaborative as their demographics and geographical location adds a unique perspective not provided by other counties. Stanislaus County is largely rural and suburban, with a smaller population and lower population density than some of the predominantly urban and suburban counties, such as Los Angeles, Orange, and San Diego. While agriculture are predominant industries in Napa, Sonoma, and Solano counties, Stanislaus would be the only participating county from the Central Valley. Stanislaus County is also a racially and ethnically diverse region. The individuals served by the EP program in Stanislaus County would provide a unique perspective in the learning collaborative.

Stanislaus County convened several events at the local level and received feedback from stakeholders regarding the Early Psychosis Learning Health Care Network multi-county collaborative. Stakeholders were invited to formally measure the level of support to move forward and pursue the proposed innovation projects through a survey, and stakeholders supported the county to move forward with this project.

Enclosed, is the staff analysis for the Stanislaus County Early Psychosis Learning Health Care Network Innovation Plan.

Stanislaus County requests that the Commission authorize up to $1,564,633 in Mental Health Services Act Innovation funds over five years to joining the Early Psychosis Learning Health Care Network (EP LHCN) Multi-County Collaborative. approved by the Commission on December 17, 2018.

2. Full-Service Partnership Multi-County Collaborative

In June 2019, the Commission approved the FSP Multi-County Collaborative to develop the foundation for FSP service programs by utilizing data driven strategies and evaluation to better coordinate and increase quality of services and improve outcomes.

The proposed Innovation Project will address Stanislaus County BHRS' FSP program challenges and needs through a thorough and inclusive approach. The project will support BHRS in implementing improvements in how they design, provide, and continuously improve FSP programs in the following ways:

- Create shared understanding of current FSP programs – who the programs are serving, how they are serving them, and what data is being collected to yield outcome measurement
- Include stakeholders in the identification of FSP program strengths and areas of improvement
- Identify problem statements that can be used to create FSP programs that are data and outcome oriented

- Develop and support data collection, analysis, and presentation processes that allow BHRS to identify disparities through demographics and outcomes data, as well as ensure individual clients are connected to appropriate and customized services to increase positive outcomes
- Identify and define FSP program outcome goals, and develop meaningful performance measures to track progress towards goals; concurrently develop sustainable processes for using the data for continuous tracking and improvement
- Clarify, streamline, and improve design and practices within FSP programs to better serve our County's FSP population and subpopulations
- Leverage other counties' processes, learning, and best practices while participating in the Multi-County FSP Innovation Project

Ultimately, this project will help BHRS meet the overarching goals of identifying priority outcomes for FSP clients, developing effective data collection techniques and ongoing measurement, creating an effective FSP framework to improve FSP client outcomes, and developing a structure for continuous evaluation of how well BHRS FSP programs are meeting community needs.

Stanislaus County is requesting up to $1,757,146 of Innovation spending authority over four and a half (4.5) years to join the Full-Service Partnership (FSP) Multi-County Collaborative for existing County specific FSP programs, originally approved by the Commission starting with Fresno County on June 25, 2019.

3. Research and Evaluation Contract Authorization:

Staff recommend authorizing the Executive Director to enter into one or more contracts not to exceed $4,244,350 with the University of California at San Francisco. The proposed contract(s) would include $3,024,350 in previously approved contract authority and $1,220,000 in new contract authority.

Prior authorizations include $2,064,350 for statewide summary evaluation of the Senate Bill 82 Triage Grant Program, $350,000 for suicide data linkage and analysis in furtherance of efforts to implement a suicide behavior research agenda, and $610,000 for one year (Fiscal Year 2021-22) of "core" data management, data analytic, and policy research support. The further $1,220,000 authorization would extend the core support functions for a further two years (Fiscal Years 2022-23 and 2023-24). Additional background materials is provided in the Enclosure.

Enclosures (3): (1) Early Psychosis Learning Health Care Network Staff Analysis; (2) FSP Multi County Collaborative Staff Analysis (3) UCSF Contract Summary

Additional Materials (2): Links to the Early Psychosis Learning Health Care Network Final Plan and FSP Multi County Collaborative Final Plan are available on the MHSOAC website at the following URLs:

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

https://mhsoac.ca.gov/sites/default/files/Stanislaus_INN_%20FSP_Multi_County_Collaborative.pdf

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

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS— STANISLAUS COUNTY

Innovation (INN) Project Name:	**Early Psychosis Learning Health Care Network**
Total INN Funding Requested:	**$1,564,633**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**June 24, 2021**

Review History:

Approved by the County Board of Supervisors:	June 15, 2021 (expected)
Mental Health Board Hearing:	May 27, 2021
Public Comment Period:	April 21, 2021- May 21. 2021
County submitted INN Project:	June 1, 2021
Date Project Shared with Stakeholders:	April 22, 2021 and June 3, 2021

Project Introduction:

Stanislaus County is requesting up to $1,564,633 of Innovation spending authority to join the Learning Health Care Network (LHCN) for existing Early Psychosis (EP) programs, a multi-county collaborative approved by the Commission on December 17, 2018.

Los Angeles, Orange, San Diego, Solano and Napa Counties were approved to contract with UC Davis Behavioral Health Center of Excellence (the Contractor) to lead the project with support from One Mind and partnerships with UC San Francisco, UC San Diego, and the University of Calgary. The multi-county collaborative will use innovation funds to develop the infrastructure for the LHCN in order to increase the quality of services and improve outcomes.

The LHCN utilizes an application (digital platform) to gather real-time data from clients and their family members in existing EP clinic settings and includes training and technical assistance to EP program providers.

The value of the full project will be examined through a statewide evaluation that will assess the impact of the Learning Health Care Network on consumer- and program-level metrics, as well as utilization and cost rates of EP programs.

What is the Problem?

The participating counties expressed that they would like to further improve outcomes for participants in EP programs while also reducing program costs. While 24 of the 59 counties in California have an EP program **there is lack of standardization and a lack of infrastructure to properly evaluate the fidelity to evidence-based practice and the effectiveness of these programs, making it impossible to disseminate best practices across programs.** These demands for effective early psychosis intervention programs combined with legislation requiring EP programs, funding to operate EP programs, and the need to implement quality improvement initiatives, has led the Collaborative to develop this proposal to create the infrastructure for a sustainable Learning Health Care Network for EP.

Stanislaus County will utilize the infrastructure and early psychosis intervention program, being provided through its partner, LIFE Path to participate in the LHCN.

LIFE Path, serves individuals, ages 14-25, and their families who have either qualified as clinically high risk (prodromal) or have experienced a first break within the past year. The program is modeled after the EASA (Early Assessment Support Alliance) program of the state of Oregon, an evidenced-based Coordinated Specialty Care (CSC) program. They have had mentorship through EASA since beginning services in 2011 and provide intensive therapeutic services, family psychoeducation, educational/vocational support, case management, and optional medication services. The LIFE Path program also includes a Parent Advocate to assist family members in negotiating educational and mental health systems.

Where the County and LIFE Path have struggled is in attempting to adapt the various measurement tools utilized by the County, that gauge a program's growth and efficacy, in a way that is in line with the needs of an early psychosis program.

Stanislaus county also identified that they have strong data regarding children receiving crisis assessments and EP referrals, but they have less reliable data on those individuals 18 and over.

Participating in the EP LHCN will support Stanislaus county to improve data collection and further refine access to early psychosis intervention based on need within their system of care.

What is the Innovation?

All counties and programs participating in this collaborative operate variations of the CSC model (a world- wide, evidence–based treatment and has been the subject of at least two recent research projects in the United States (Azrin, Goldstein, Heinssen, 2016)).

The LHCN seeks to create infrastructure in California to gather real-time data from clients and their family members in existing EP clinic settings that use CSC. Data will be collected through a developed application via questionnaire on tablets. The collection of data via application and subsequent aggregation will allow programs to learn from each other and

provide the infrastructure to position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US.

The Collaborative proposal identified three primary areas of focus:

1. Provide infrastructure for an EP Learning Collaborative across counties, in which common challenges can be identified and "lessons learned" can be quickly disseminated, creating a network of programs that rapidly learn from and respond to the changing needs of their consumers and communities.
2. Training and technical assistance to support EP program providers to have immediate access to relevant client-level data and anonymized data that can be quickly shared with stakeholders, the county, or the state. Rapid dissemination of program outcomes has historically been a challenge for county-based programs.
3. Evaluation of the LHCN will provide information on how to incorporate measurement-based care into mental health services and demonstrate impact of the LHCN on the recipients and providers of EP care.

As a result of the project, Counties will be able to learn from each other and from leading experts in early psychosis treatment by using a common framework to improve processes and report on outcomes. Currently, counties have no easy way to share data from early psychosis programs and this LHCN is one solution providing a starting point to address the lack of shared data systems.

With the addition of Stanislaus County to the EP LHCN, the County hopes to increase their understanding of the most effective engagement and treatment approaches to decrease the duration of untreated psychosis and maximize early detection of psychosis symptoms.

The EP LHCN Project aligns with the current challenges of the LIFE Path program and will improve the program's ability to:

- **Increase fidelity to current evidenced-based practices including effective and efficient service delivery.**
- **Improve data collection, tracking, analysis, and reporting.**
- **Provide participants, counselors, and administrators access to data in real-time.**
- **Engage participants and family members in treatment and recovery.**

By joining the LHCN, Stanislaus County adds value to the learning collaborative as their demographics and geographical location adds a unique perspective not provided by other counties. Stanislaus County is largely rural and suburban, with a smaller population and lower population density than some of the predominantly urban and suburban counties, such as Los Angeles, Orange, and San Diego. While agriculture are predominant industries in Napa, Sonoma, and Solano counties, Stanislaus would be the only participating county from the Central Valley. Stanislaus County is also a racially and ethnically diverse region. The individuals served by the EP program in Stanislaus County would provide a unique perspective in the learning collaborative.

Community Planning Process (see pages 3-4 of the County appendix)

Local Level

Stanislaus county operates a Representative Stakeholder Steering Committee for MHSA guidance. Following six stakeholder meetings, Stanislaus county introduced the opportunity to join two, statewide multi-county collaboratives: Early Psychosis Learning Health Care Network and the Full-Service Partnership project. The County then conducted an information session detailing each project with time for discussion and questions. Following the innovation information session, stakeholders were invited to formally measure the level of support to move forward and pursue the proposed innovation projects through a survey utilizing the gradients of agreement scale. Stakeholders supported the county to move forward with these projects.

State level

Through a contract with the Commission from July-November 2018, the Contractor, UC Davis, worked to engage stakeholders, including clients served by EP programs and their families, the leadership and clinical providers within EP programs, county and state leadership, as well as community organizations in the development of this proposal.

The Collaborative reports that the proposed project follows a policy of 'nothing about us without us', including community stakeholder involvement at all levels of the project.

The qualitative component of the proposed project will continue stakeholder engagement throughout the 5-year proposed project. The Collaborative is relying on participating stakeholders to guide them on how to best serve the diverse communities of each EP program.

In addition, the Collaborative formed an Advisory Committee after reaching out to engage diverse communities to ensure representation includes underserved populations.

Multiple letters of support were received in response to the original proposal. Please see pages 72-77 of full plan for more information.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on April 22, 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 June 3, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

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

Learning Objectives and Evaluation:

As part of the LHCN collaborative, Stanislaus County will follow the evaluation approach as laid out in the full LHCN plan. Key components of the evaluation plan are summarized below:

The LHCN will target individuals at increased risk or in the early stages of a psychotic disorder and estimate that approximately 2,000 individuals will be served over the course of the project. Three approaches to the evaluation will be taken. These three approaches coalesce into a robust evaluation that meet the goals of the project and include: the utility of the LHCN for early psychosis programs, fidelity of early psychosis programs within counties, as well as the impact that early psychosis programs have on costs and individual outcomes—each approach is summarized below.

(1) *Utility of the LHCN for early psychosis programs*: This will be accomplished by utilizing information gathered from two samples of consumers and providers prior to LHCN implementation. The first sample of consumers will complete questionnaires at year 1 (pre-implementation period). Questionnaires will gather information on knowledge of illness, Perceived Effect of Use for the LHCN, Treatment Satisfaction, Treatment Alliance, and Comfort with Technology. Providers will also complete a questionnaire on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. The second sample of consumers and providers will complete these same questionnaires post-implementation at year 4.

(2) *Fidelity of early psychosis programs*: Using the revised First Episode Psychosis Services Fidelity Scale (FEPS-FS), the Collaborative will assess each clinic's adherence to evidence-based practices for first-episode psychosis services. Scores from the FEPS-FS will provide insights into components of each EP program that are associated with outcomes.

(3) *Impact of early psychosis programs on costs and outcomes*: Using three different data sources—program-level data, qualitative data, and county-level data—the impact that EP programming has on individual consumer outcomes as well as related costs will be examined (**see pgs.12-16 of Collaborative plan**).

a. Program-Level Data: upon consideration from stakeholder engagement discussions (**see qualitative data**), specific data elements will be selected and will stand as the foundation for the LHCN. Providers, consumers, and family members will identify measures of potential outcomes from the PhenX Early Psychosis Toolkit, the national Mental Health Block Grant, and others (**for specific measures and outcomes, see pgs. 13-15 of Collaborative plan**).
b. Qualitative Data: focus group interviews, and in-depth semi-structured interviews will be conducted with consumers, family members, and providers. With this method, feedback will be garnered at different stages

of the project. This includes feedback relative to identifying appropriate measures for use in the project. Additionally, these methods will allow evaluators to assess the feasibility of the implementation strategy and provide context to the interpretation of data analysis.

c. County-Level Data: consumer-level data relative to program service utilization, crisis/ED utilization, psychiatric hospitalization, and costs related to these utilization domains will be captured at the county-level.

These three evaluation approaches will be guided by several learning questions, **please see pages 9-13 in the Collaborative plan.**

Data collection and analysis for the LHCN evaluation will take place in multiple stages throughout the 5-year project (**see pg. 18 of Collaborative plan**). UC Davis and partners will be responsible for data analysis and writing the final evaluation report.

The Budget

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	Contractor/ Evaluation	% for Evaluation	Sustainability Plan (Y/N)
Stanislaus	$1,564,633	$1,140,585	$424,048	27.10%	Y
Previously approved:					
Los Angeles	$4,545,027	$1,575,310	$2,969,717	65.34%	Y
Orange	$2,499,120	$1,573,525	$925,595	37.04%	Y
San Diego	$1,127,389	$201,794	$925,595	82.10%	Y
Solano	$414,211	$291,399	$122,812	29.65%	Y
Napa	$258,480	$218,820	$39,660	15.34%	Y

Total	**$10,408,860**	**$5,001,433**	**$5,407,427**	**52%**

With the addition of Stanislaus County, UC Davis will receive $5,407,427 (52%) to manage the project, hire consultants, sub-contractors and complete the evaluation. Each participating county is paying a percentage of the contract with UC Davis based on the county size.

Stanislaus County will retain $1,140,585 for personnel, operating and contractor costs.

The total personnel cost for the county portion is $822,374 over five years and include:

- 0.5 FTE Software Developer/Analyst III with duties including: identify the appropriate county-level data and data transfer methods; extract county-level data from the electronic health record and other program databases and sources; and de-identify data before transferring to contracted staff.

- 0.5 FTE Staff Services Coordinator with duties including: overseeing project contractor, coordinating meetings and staff, monitoring project timelines, providing trainings and communicating with stakeholders.

The two positions are not exclusive to an administrative and oversight role but are designed to support and coordinate the project based on the recommendations from UC Davis and the current participating counties, and to meet resource capacity need for the program and project to be successful.

The total contractor costs are $276,611 over five years and include staffing a program assistant to:

- Instruct and support clients and family members in the use of technology for data collection.
- Educate new clients and families on Innovation project and gather consents for projects.
- Monitor timeliness of data collection from clients and family members.
- Scheduling client and families to complete core battery on tablet at each follow up.
- Assist in coordination with UCD and BHRS.

In addition to County contributions, One Mind awarded UC Davis a $1.5 million grant to support this project. UC Davis utilized the grant to provide the necessary support to extend from a three-year project to a five-year project.

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

Collaborative Update:

- Outcomes focus groups concluded- 26 groups with client, families, and staff, including some in Spanish (184 individuals).
- Additional focus groups conducted to get stakeholder feedback on data-sharing (6 groups) and the design of the custom-built application (14 groups).
- Pilot testing of the custom-built application has begun in 2 LHCN programs (4 programs total across EPI-CAL).
    - Clients have been enrolled and outcomes data collection has begun.
- Data was received from EP programs for the retrospective data pull for the cost and utilization analysis.
- LHCN has had an impact on EP program data collection at the national level, as our team has shared our qualitative approach as a template for other EPINET hubs to follow. LHCN is also leading the work group on diversity, equity, and inclusion.

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STAFF ANALYSIS—Stanislaus County

Innovation (INN) Project Name:	**Full-Service Partnership (FSP) Multi-County Collaborative**
Total INN Funding Requested:	**$1,757,146**
Duration of INN Project:	**4.5 Years**
MHSOAC consideration of INN Project:	**June 2021**

Review History:

Approved by the County Board of Supervisors:	June 15, 2021 (Expected)
Mental Health Board Hearing:	May 27, 2021
Public Comment Period:	April 21, 2021- May 21, 2021
County submitted INN Project:	April 07, 2021
Date Project Shared with Stakeholders:	April 21, 2021 and June 3, 3021

Project Introduction:

Stanislaus County is requesting up to $1,757,146 of Innovation spending authority to join the Full-Service Partnership (FSP) Multi-County Collaborative for existing County specific FSP programs, originally approved by the Commission starting with Fresno County on June 25, 2019.

Four additional counties (Sacramento, San Bernardino, Siskiyou, and Ventura) joined and were approved by the Commission on June 5, 2020. The Commission contracted with Third Sector who worked collaboratively with the above Counties by administratively guiding counties through the development and implementation of this project, and supports the use of innovation funds to develop the foundation for FSP service programs by utilizing data driven strategies and evaluation to better coordinate and increase quality of services and improve outcomes.

The county of San Mateo did not request approval for use of Innovation funding to the project. Instead, they utilized CSS and other one-time funds totaling $750,000.

Full-Service Partnerships are designed to support individuals requiring services with the most severe mental health needs and co-occurring disorders. The FSP model serves this most severe population, for all age groups, and mandates a doing “whatever it takes” approach to provide services to those in need to help individuals on their path to recovery and wellness.

What is the Problem?

FSP programs have encountered two significant barriers in the facilitation and delivery of the “whatever it takes” model, interfering with the delivery of the FSP promise. (1) Specific FSP

programs are difficult to establish, support and treat underserved populations, (2) data collection coordination has not been established and/or consistently implemented. Delivering on the promise requires defining what components are essential and establish standardization for statewide FSP services. Service coordination to evaluate essential components of FSP service programs is limited by the lack of data collection, sharing and evaluation for establishing best practice service deliverables from the results.

Stanislaus County proposes to invest in this FSP Innovation to improve program data sharing, program outcomes, and implementation of learnings to improve the quality and inclusiveness of efficacious FSP services. The program will allow the County to evaluate current local services and their successes, while addressing uncovered challenges, and identify needs for program improvement as well as Culturally Competent inclusiveness.

Stanislaus County expressed consideration that the existing eight FSP programs offered may not address or clearly reflect current county needs, though successfully providing services for 833 clients in FY 2019-2020. The demographic data indicates that the County is addressing the needs predominantly with white consumers at 53%; Hispanic 29%; Asian 4%; Native American 2%; Other 2%; Pacific Islander 1%; and 1% unknown. In comparison, Stanislaus County's current population of 557,709 most recent demographics, according to statistics based on the Department of Finance from January 2020, are as follows: Hispanic/Latino 45.6%; White 42.6%; Asian 5.3%; Black 2.6%; Two or more races (not Hispanic/Latino) 2.5%; Native Hawaiian or Pacific Islander 7%; American Indian and Alaskan Native 5%; and Other Race (not Hispanic /Latino) 2%. Despite the diversity of the population, Stanislaus County has only one threshold language; Spanish.

The County identified multiple issues that affect the ability to achieve current FSP goals including:

- Challenging to consistently obtain accurate data collection
- Accurate administration and training of data collection tools
- Lack of adequate staffing to analyze, present, and interpret data
- Monitoring and adequate resources for continuous data consistency and improvement
- Synthesizing stakeholders perspectives for appropriate use of meaningful data and outcomes
- Data-driven programmatic design/revisions are difficult to implement and sustain

It has been over decade since implementation of FSP programs and the County is dedicated to evaluating what is working, not working, areas in need of improvement, and inclusion of new and/or updated treatment modalities. **Stanislaus County will work with Third Sector in collaboration with the six counties previously approved to properly identify service deficiencies, evaluate methodology, share FSP data and outcomes with the goal of collectively ensuring inclusive programmatic fidelity for all demographics and to deliver quality and robust mental health services for all FSP consumers.**

How this Innovation project addresses this problem:

The FSP Innovation project will establish a process for collecting and analyzing data to allow counties to make outcome-driven decisions, provide incentive-based services, and improve the quality of FSP services. Stanislaus plans to join the collaborative of six other counties that contracted with Third Sector Capital Partners to develop a process for the following five distinct areas of focus:

1. Defining and Tracking Priority Outcomes: there is a strong need for FSP service program improvement through data collection and evaluation to help define and track

past and current performance measures as well as outcomes. The data will assist in establishing a *best practice* approach to track, standardize, and apply measures consistently between counties and across programs for statewide consistency.
2. Develop and/or Strengthen Processes: establish new processes including supporting shared learning collaborations, accountability, develop and strengthen existing processes for continuous improvements, support meaningful comparisons, and utilize data to provide continuous improvements of FSP services for clients statewide.
3. Strategy to Track and Streamline Performance Measures: evaluate state-level and county-specific reporting tools to develop strategies for best tracking performance measures and outcomes.
4. Develop a Consistent FSP Framework: develop a *best practice* FSP framework and consistent interpretation of core components that allow adaptations for county specific needs.
5. Define Program Criteria: define clear and consistent eligibility, enrollment, referrals, and graduation criteria. Develop county and provider guidelines for dissemination of information and implementation protocols.

Stanislaus County will apply a Human-Centered Design (HCD) approach to their stakeholder engagement to ensure all initiatives are co-developed by the community and address the Stanislaus County's FSP consumers' unique programmatic needs.

The identified four primary areas of focus, specific to the Stanislaus County's challenges:
1. Clearly identify primary areas of focus
2. Develop effective data collection and tracking mechanisms to increase the accuracy and meaning of FSP data for transforming into performance measures and outcomes
3. Create an FSP framework and practices that foster continuous improvement of outcomes for FSP clients
4. Develop sustainable ways to continuously evaluate how BHRS FSP programs are effectively meeting the community needs

Community Planning Process (Pages 4-5 of the County Appendix & Page 65 of Third Sector-FSP)

Local Level

- Briefly describe their process and why is this change important for their community?
- Include dates and if those who will benefit from the project were consulted

Stanislaus County created a more robust stakeholder process during the COVID-19 pandemic by offering four Formal Representative Stakeholder Steering Committee (RSSC) meetings in 2020, instead of two, held on June 12, June 26, September 18, and December 11, with each meeting averaging 62-80 participants. Stanislaus County has funds subject to reversion and decided on two multi-county collaboratives that aligned well with the new and more robust stakeholder process established for future innovation projects, including: Full-Service Partnership (FSP) and the Early Psychosis Learning Health Care Network (LHCN), as the projects best suited to serve the County's current needs. Following the decision to move these projects forward, stakeholders were invited to formally measure the level of support and pursue the proposed innovation projects through a survey utilizing the gradients of agreement scale. Stakeholders unanimously supported moving this project forward. Public comment was posted April 21, 2021 - May 21, 2021, and no comments were received.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on April 21, 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 June 3, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

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

Learning Objectives and Evaluation:

To guide their project, the counties have identified several learning questions that are centered on both systems-level and client-level outcomes. These learning questions include:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collections and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within each participating county?
6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?
7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the outcomes-driven FSP learning community and collective group of participating counties?
8. Which types of collaborative forums and topics have yielded the greatest value for county participants?
9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

Stanislaus County will incorporate the evaluation and methodology identified in the FSP plan developed by Third Sector. Third Sector (Contractor) and RAND (Evaluator) assisted the initial six counties in finalizing the overall goals, learning questions, measures, data sources, and will work with Stanislaus County to finalize the same. Stanislaus County, in collaboration with the initial counties, will utilize both quantitative and qualitative data to evaluate the project.

For System-level Impacts and Outcome-Level Impacts, (please see pgs. 12-14 of the County plan).

Stanislaus County's specific goals for this project also include:

- Clearly identify outcomes for FSP clients
- Develop effective data collection and tracking mechanisms to increase the accuracy and meaning of FSP data for transforming into performance measures and outcomes

- Create an FSP framework and practices that foster continuous improvement of outcomes for FSP clients
- Develop sustainable ways to continuously evaluate how BHRS FSP programs are effectively meeting the community needs

The Budget

County	Fresno	Sacramento	San Bernardino	Siskiyou	Ventura
Total INN Approved Funding	$950,000	$500,000	$979,634	$700,001	$979,634
Duration of INN Project	4 Years	4.5 Years	4.5 Years	4.5 Years	4.5 Years

County	INN Funding Requested	Local Costs for Admin and Personnel	Contractor/ Evaluation	Operating Costs	Non-Recurring Costs
INN FUNDING REQUESTED	**$1,757,146**	$648,035	$1,073,651	$24,560	$10,900

Total	**$1,757,146**				

Stanislaus County is requesting authorization to spend up to $1,757,146 in MHSA Innovation funding for this project over a period of Three (3) years.

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

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Consent Calendar Agenda Item 3: Research Contract Authorization Background

Commission staff recommend authorizing the Executive Director to enter into a contract, "Partnering to Build Success in Mental Health Research and Policy," in the amount of $4,244,350, with the University of California at San Francisco. This contract authorization is proposed for consideration under the Commission's consent calendar procedure, as the Commission has previously authorized for the designated purposes the majority of the funding in the proposed contract.

The proposed contract is for a term of three years, Fiscal Years 2021-22 through 2023-24. The proposed scope includes three main components:

1. Statewide summative evaluation of the grants provided under the SB 82 Triage Grant program ($2,064,350, disencumbered and redirected from prior Triage evaluation contracts) of this amount is funds disencumbered from the UCLA and UCD Triage evaluation contracts.
2. Suicide data linkage and analysis ($350,000 of $500,000 authorized by the Commission's approval to create a suicide behavior research agenda at the September 24, 2020 meeting).
3. Continuity on support for core data management, data analysis, data visualization, and policy project efforts. The Commission authorized $610,000 for one year of further work effort in the July 23, 2020 meeting. This portion of funding would cover core work efforts for the FY 2021-22 year. Staff seek authorization to expend up to an additional $1.22 million to extend the core work through FYs 2022-23 and 2023-24.

This contract is proposed for a three-year term to meet Triage evaluation and data analytics to support suicide prevention efforts over the proposed term, as well as to provide stability to the staff expertise we are acquiring/maintaining through the contract. Authorizing the core work efforts to also cover FYs 2022-23 and 2023-24 would align the terms of all three work efforts.

The core work efforts provide "embedded" staff resources who extend and supplement the capacity of the Commission's full-time, permanent research staff in critical ways. The Research and Evaluation Division relies on the expertise of embedded staff to provide essential SAS and database programming, analytics, and data management functions, all of which support and extend the capacity of our full-time state research staff. For example, these staff support the Commission's ongoing database management and data linkage activities spanning data from the Department of Health Care Services, California Department of Education, California Department of Public Health, California Department of Justice, Employment Development Department, and others. These contract staff also provide critical training and technical advisory support to increase the knowledge, skills, and abilities of our permanent, full-time research staff.

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Additionally, as noted above, the contract provides resources for Triage summative evaluation project management and analytical capacity necessary to complete the legislatively mandated, statewide evaluation of the Triage grant program. This staff will be responsible for data linkages and analyses to support the Commission's direction to begin implementation of Strategic Aim 1: Goal 3: Advance Data Monitoring and Evaluation in Striving for Zero: California's Strategic Plan for Suicide Prevention.

Key changes from the current, expiring contract include the following:

1. The contract term is expanded to three years from two in the preceding contract, 18MHSOAC040.
2. Added activity for supporting implementation of data analytics described in the Commission's adopted statewide strategic plan for suicide prevention, Striving to Zero: California's Strategic Plan for Suicide Prevention.
3. Added activity to complete the statewide summative evaluation of the Triage program. An amendment to the current contract provided for bridge funding to begin implementation of the summative evaluation activities during this fiscal year, with the expectation that the balance of the evaluation costs would be incorporated in this new contract.
4. The contract is expanded to $1,414,783 per year from $628,504 per year, reflecting changes in scope described above.

AGENDA ITEM 3

Action

June 24, 2021 Commission Meeting

Multi-County Collaborative 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. **Psychiatric Advance Directives (PADs) Multi County Collaborative**

The Commission has launched an Innovation Incubator to deliver technical assistance to counties seeking to collaborate on and learn from innovative investments to reduce criminal justice involvement of people with mental health needs.

The Commission completed a project to identify ways to reduce the number of people with mental illness in our criminal justice system. The project report highlighted the dramatic increase in the number of mental health consumers in our criminal justice system. The Commission's criminal justice report recommends that counties develop diversion strategies to keep people with mental health needs out of the criminal justice system—but identified that there is little capacity for technical assistance to meet the demand.

Subsequently, the Governor and Legislature authorized the Commission to develop an innovation incubator to leverage mental health innovation funds to transform approaches to mental health by focusing on prevention, early intervention, recovery, and outcomes that promote health, safety, independence, and opportunity. The Innovation Component of the Mental Health Services Act (MHSA) provides an opportunity to explore new ways to organize and deliver mental health services. To support those goals, the Commission is working to provide strategic guidance, support technical assistance and training, enhance evaluation to document impact, and disseminate information to create statewide systems improvement.

People with mental health needs, at times, may not be able to have a collaborative interaction with service providers or emergency personnel, such as law enforcement, especially if the person is in crisis. Behavior exhibited by a person in crisis may draw the attention of law enforcement, thereby initiating a path into the criminal justice system.

Practices that establish care directed by the person with mental health needs before a crisis show promise in preventing disruption of community-based services. The use of psychiatric advance directives is one method to explore using innovative funding to expand the tools available to local behavioral health departments.

As part of the Commission's portfolio of Innovation Incubator projects, Mariposa, Orange, Shasta, and Monterey Counties are seeking approval to use innovation funds to develop a sustainable infrastructure within California to utilize Psychiatric Advance Directives (PADs). Fresno County was already approved to participate in this Multi-County Collaborative on June 5, 2020, and is requesting additional funds to allow for contribution towards the cost of administrative fees and statewide coordination.

COUNTY	Total INN Funding Requested	Duration of INN Project
Mariposa	$517,231	4 Years
Orange	$12,888,948	4 Years
Shasta	$630,731	4 Years
Monterey	$1,978,237	4 Years
Fresno	$500,000	5 Years
TOTAL:	**$ 16,515,147**	

The overarching goal of this project is for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training and a toolkit, as well as create a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

This project was developed, in part, through the work of the Commission to identify opportunities to reduce criminal justice involvement of mental health consumers through improved access to community mental health services. The Commission is providing financial support to the Saks Institute for Mental Health, Law, Policy and Ethics to assist with the project, by providing technical assistance on the development and deployment of psychiatric advance directives, supporting the understanding of PADs through the development of policy and practice briefs and to convene meetings with interested counties to support awareness, understanding and participation in this Multi-County Innovation Project. Additionally, the Commission has contracted with Concepts Forward (Project Manager) who has worked with the above Counties and their communities to create this Multi-County Innovation Plan and join Fresno County.

The Commission's support for this project as part of the Innovation Incubator, recognizes that many individuals at risk for involuntary care encounter the criminal justice system through a mental health crisis. Research conducted by the California Department of State Hospitals indicates that nearly half of persons sent to a state hospital under Incompetent to Stand Trial statutes for a felony arrest had multiple prior contacts with law enforcement with little or no access to community based mental health care. This project is an innovation to explore the utility of psychiatric advance directives as a strategy to improve the effectiveness of community-based care for persons at risk of involuntary care, hospitalization, and criminal justice involvement.

This project will provide individuals with the ability to make decisions on their own behalf relative to their own mental health needs. Some of the proposed outcomes of this project will result in the following (see pgs. 3-4 of project plan for a complete list):

- Provision of standardized training on the usage and benefits of PADs by stakeholders
- Creation of a standardized PAD template with the facilitation of peers with lived experience
- Development of a training tool-kit to be used throughout various counties while maintaining reliability and consistency
- Creation and implementation of a cloud-based technology platform to utilize PADs

Cultural Competency and Community Planning Process
Orange, Mariposa, Shasta, Monterey, and Fresno Counties each demonstrated that this project was reviewed and supported by their communities through robust local community planning process.

Through two Innovation Incubator contracts with USC Gould School of Law/Saks Institute and Concepts Forward Consulting, robust stakeholder efforts were inclusive of stakeholders, clients with lived experience who have utilized PADs, consumers families, leadership and clinical providers, county, and state leadership, as well as community organizations in the creation of this proposal.

Commission staff originally shared this project with its six stakeholder contractors and listserv on May 4, 2021 and June 8, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees on both dates indicated above.

Four comments were received in response to Commission sharing this plan with stakeholder contractors and the listserv and have been provided for review.

There were two letters of support received and have been included with the Collaborative Project (see Appendix B).

Enclosures (3): (1) Biography for the PADS Multi County Collaborative Innovation Presenter; (2) Staff Analysis: PADs Multi-Collaborative; (3) Stakeholder Letters of Opposition and Support

Handout (1): PowerPoint Presentation: **Psychiatric Advance Directives (PADs) Multi County Collaborative**

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

Psychiatric Advance Directives (PADs) Multi County Collaborative:

https://mhsoac.ca.gov/sites/default/files/Multi%20County_INN_PADs_0.pdf

Proposed Motions (5): The Commission approves each of the PADS Multi- County Collaborative Innovation plans, as follows:

COUNTY	TOTAL INN FUNDING REQUESTED	DURATION OF INN PROJECT
Mariposa	Up to $517,231 in MHSA INN funding	4 Years
Orange	Up to $12,888,948 in MHSA INN funding	4 Years
Shasta	Up to $630,731 in MHSA INN funding	4 Years
Monterey	Up to $1,978,237 in MHSA INN funding	4 Years
Fresno	Additional funding up to $500,000 in MHSA INN funding	5 Years
	TOTAL: $16,515,147.00	

Psychiatric Advance Directives (PAD) Innovation Project
Presenter: Kiran Sahota, MA

Kiran Sahota has been the president of Concepts Forward Consulting since 2020. Her prior positions include over 25 years in the social service sector, county and non-profit employment. She was a Senior Behavioral Health Manager for Mental Health Services Act (Proposition 63) within a California Mental Health Plan from 2014 to 2020. Ms. Sahota was also an Administrator for a countywide law enforcement Crisis Intervention Team (CIT) training within the local Sheriff's Office from 2012 to 2014. Ms. Sahota's project management expertise is focused on suicide prevention efforts, mental health advocacy, stakeholder engagement, innovations, and law enforcement training. Ms. Sahota received her Master of Community and Clinical Psychology from California State University Northridge.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS - MULTI-COUNTY COLLABORATIVE

Innovation (INN) Project Name:
Psychiatric Advance Directives

Review History

COUNTY	Total INN Funding Requested	Duration of INN Project	30-day Public Comment
Mariposa	$517,231	4 Years	5/13/21-6/13/21
Orange	$12,888,948	4 Years	4/23/21-5/23/21
Shasta	$630,731	4 Years	5/24/21-6/23/21
Monterey	$1,978,237	4 Years	4/23/20-5/22/20
Fresno	$500,000	5 Years	4/26/21-5/25/21
TOTAL:	**$ 16,515,147.00**		

Project Introduction

Mariposa, Orange, Shasta, and Monterey Counties are seeking approval to use innovation funds to develop a sustainable infrastructure within California to utilize Psychiatric Advance Directives (PADs). Fresno County was already approved to participate in this Multi-County Collaborative on June 5, 2020 and is requesting additional funds to allow for contribution towards the cost of administrative fees and statewide coordination.

The overarching goal of this project is for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training and a toolkit, as well as create a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Psychiatric advance directives (PADs) are advance directives used to support treatment decisions for individuals who may not be able to consent to or participate in treatment decisions because of a mental health condition. They generally are used to support decision-making for people at risk of a mental health crisis where decision-making capacity can be impaired. The psychiatric advance directive allows the individual's

wishes and priorities to inform mental health treatment. Like their general health care counterpart, psychiatric advance directives also can allow an individual to designate proxy decision-makers to act on their behalf in the event the individual loses capacity to make informed decisions.

Identified Need

There is widespread support for the use of Psychiatric Advanced Directives to empower people to participate in their care, even during times of limited decision-making capacity. PADs are a recognized strategy to improve the quality of the caregiver-client relationship and to improve health care outcomes (Swanson, et al., 2006). More than half of the states have explicitly authorized some form of a psychiatric advance directive and standard health care power of attorney statutes extend that authorization throughout the U.S. (Appelbaum, 2004). The Joint Commission on the Accreditation of Healthcare Organizations recognizes the value of psychiatric advance directives for treatment decisions when an individual is unable to make decisions for themselves (JCAHO, Revised Standard CTS.01.04.01).

While psychiatric advance directives were first put into use in the U.S. in the 1990s, and have widespread support, research suggests their use is limited by lack of awareness, and challenges with implementation.

Although 27 states have passed laws recognizing PADs, most PADs are incorporated with the main emphasis on physical health. Adding to this is that there is not a standardized template for individuals, or their support systems, to access it when they might need it the most.

With the increasing rates of mental illness and high rates of recidivism, steps need to be taken so that directives are in in place in the event a person experiences a psychiatric episode.

How this Innovation project addresses the need:

This project was developed, in part, through the work of the Commission to identify opportunities to reduce criminal justice involvement of mental health consumers through improved access to community mental health services. The Commission is providing financial support to the Saks Institute for Mental Health, Law, Policy and Ethics to assist with the project, by providing technical assistance on the development and deployment of psychiatric advance directives, supporting the understanding of PADs through the development of policy and practice briefs and to convene meetings with interested counties to support awareness, understanding and participation in this Multi-County Innovation Project. Additionally, the Commission has contracted with Concepts Forward (Project Manager) who has worked with the above Counties and their communities to create this Multi-County Innovation Plan and join Fresno County.

The Commission's support for this project recognizes that many individuals at risk for involuntary care encounter the criminal justice system through a mental health crisis. Research conducted by the California Department of State Hospitals indicates that nearly

half of persons sent to a state hospital under Incompetent to Stand Trial statutes for a felony arrest had multiple prior contacts with law enforcement with little or no access to community based mental health care. This project is an innovation to explore the utility of psychiatric advance directives as a strategy to improve the effectiveness of community-based care for persons at risk of involuntary care, hospitalization, and criminal justice involvement.

This project will provide individuals with the ability to make decisions on their own behalf relative to their own mental health needs. Some of the proposed outcomes of this project will result in the following (see pgs 3-4 of project plan for a complete list):

- Provision of standardized training on the usage and benefits of PADs by stakeholders
- Creation of a standardized PAD template with the facilitation of peers with lived experience
- Development of a training toolkit to be used throughout various counties while maintaining reliability and consistency
- Creation and implementation of a cloud-based technology platform to utilize PADs

Discussion of County Specific Regulatory Requirements

Mariposa

The County of Mariposa hopes this project will allow for their community to make important decisions for their overall wellbeing along with the ability for agencies and organizations within their community to collaborate and leverage resources for this small, rural community.

The County states that due to the isolation of their geographic location, there are high utilization rates of local hospital and crisis response programs.

Mariposa County held their 30-day public comment period from May 13, 2021, through June 13, 2021, and held their Behavioral Health Board meeting on June 14, 2021. Stakeholders, community partners, as well as consumers and family members were welcome to provide feedback around innovation projects. Any feedback received during the public review period will be incorporated into the continuing development and subsequent phases of this project.

Mariposa proposes to spend up to $517,231 in Innovation funding towards this multi-county collaborative.

Orange

Experiencing a 27% increase in suicide deaths between 2015- 2018, the Orange County community has identified a need for additional support and integrated services between the behavioral health and crisis service systems of care.

The County's 30-day public comment period began on April 23, 2021, followed by a public health board hearing on May 26, 2021. The County anticipates receiving Board of Supervisor approval on June 22, 2021.

A large portion of Orange County's budget is being allocated towards the development and creation of a Chorus platform. This platform will allow the exchange of health information and for PADs to be housed in a centralized location. Additionally, this platform would allow law enforcement hospitals and correctional health facilities to access PADs to coordinate care previously specified by the individual.

Other counties in this cohort are not required to participate in the Chorus platform; however, if they do, Counties and their communities will be invited to participate in workgroups to provide input on the development of the PADs platform.

Orange County proposes to spend up to $12,888,948 Innovation funding towards this multi-county collaborative.

Shasta

Shasta County began their 30-day public comment period on May 24, 2021, followed by their Behavioral Health Board Hearing on June 23, 2021, and is expected to appear before their Board of Supervisors on June 29, 2021.

Community feedback in the County has disclosed that individuals and their families feel helpless when interacting with law enforcement and the hospital system and the use of a Psychiatric Advance Directive would empower individuals to be in control of their own decision making even when they may be incapacitated to make critical decisions.

Shasta County proposes to spend up to $630,731 in Innovation funding towards this multi-county collaborative.

Monterey

Monterey held their 30-day public comment beginning April 23, 2020, following by their local Mental Health Board Hearing on May 28, 2020, receiving Board of Supervisor approval on June 30, 2020.

In October 2019, efforts began in the County to introduce ideas and concepts for innovation involving 10 bilingual community workshops County-wide allowing the community to provide input and feedback on the various projects that could potentially be funded with MHSA dollars. The PADS innovation project was endorsed during the community planning process and then received continued endorsement by the County's Behavioral Health Commission and Board of Supervisors.

Members in the County called for enhanced crisis response training inclusive of consumer and family driven services. Monterey County hopes to prosper on the collaboration between service providers and consumers for a more interconnected system of care for individuals.

Monterey proposes to spend up to $1,978,237 in Innovation funding towards this multi-county collaborative.

Fresno

Fresno was originally approved for up to $950,000 in innovation spending authority for the Psychiatric Advance Directive project in June 2019 over three years. Fresno began researching PADs and will now begin working with collaborating counties to further develop this project. Due to the COVID pandemic, efforts in Fresno County were stalled and County resources were allocated to where the needs were the greatest. Fresno County notified the Commission in August 2020 that they were extending their project for an additional two years to extend the time available to implement their project.

Proposed changes were made to the Behavioral Health Board on April 21, 2021, followed by the 30-day public comment period from April 26, 2021 through May 25, 2021. Several virtual forums to solicit feedback were held and these changes will be provided in the MHSA Annual Update. The County plans to hold their public Behavioral Health Board Hearing on June 16, 2021 and will obtain Board of Supervisor approval pending Commission approval.

Fresno proposes to spend an additional $500,000 in Innovation funding towards this multi-county collaborative.

Cultural Competency and Community Planning Process

Orange, Mariposa, Shasta, Monterey, and Fresno Counties each demonstrated that this project was reviewed and supported by their communities through robust local community planning process.

Through two Innovation Incubator contracts with USC Gould School of Law/Saks Institute and Concepts Forward Consulting, robust stakeholder efforts were inclusive of stakeholders, clients with lived experience who have utilized PADs, consumers families, leadership and clinical providers, county and state leadership, as well as community organizations in the creation of this proposal.

Learning and Evaluation

Similar to Fresno County's previously approved PADs project approved in June 2019, this cohort of Counties will be joining to focus on the following learning objectives and goals:

1. Improved compliance.
2. Increase in adherence to treatment requests.
3. Increase in individual wellness scores: measured through various screening tools, such as the Recovery Needs Level (RNL) of individuals as well as through individual participation in services.
4. Reduction in incarceration/criminal justice involvement: measured through a reduction in arrests and incarcerations among those experiencing psychiatric crisis who have are provided with care according to their wishes.

5. Reduction in long term hospitalization.

Additionally, this collaborative has identified the additional two goals, supplementing the established objectives above (see pgs 10-11 for detailed objectives):

1. Successful implementation of PADs for participating counties
    a. Evaluate peers' training-related outcomes
    b. Assess areas for improvement relative to training
    c. Document PADs process implementation within Counties
    d. Assess PADs completion across participating Counties

2. Positively affect consumer outcomes utilizing PADs
    a. Assess consumers' experience with PADs
    b. Assess and quantify consumer's experiences with PADs

The RAND Corporation has been chosen as the contractor for the evaluation component in this project and will assess how well the two goals indicated above were met. Data will be gathered and analyzed by focus groups, targeted consumer and stakeholder conversations as well as survey questionnaires. The County is selecting this contractor due to their ability to operate independently without pressure from outside or political influences.

The Budget

COUNTY	Total INN Funding Requested	Local Costs - Admin and Personnel	Contractor/ Evaluation	% for Evaluation	Sustainability Plan (Y/N)
Mariposa	$517,231	$437,614.13	$79,660	15.4%	Y
Orange	$12,888,948	$1,043,478	$11,845,470	91.9%	Y
Shasta	$630,731	$423,000	$207,731	32.9%	Y
Monterey	$1,978,237	$759,411	$1,218,826	61.6%	Y
Fresno	$500,000	-	$500,000	100%	Y
Total	**$16,515,147**		**$13,851,687**		

Mariposa, Orange, Shasta, Monterey, and Fresno counties are collectively contributing $16,515,147 of innovation dollars to fund the Psychiatric Advance Directives project for four years. Fresno was approved for a three-year project duration on June 5, 2020, with an extension of time (additional two years) acknowledged in August 2020. For this project, Fresno is seeking additional funding in the amount of $500,000.

Each of the counties in this cohort are contributing towards consultant and evaluation costs for a total amount of $13,851,687 (83.9% of the total project amount). This project

will partner with the following contractors for the development, implementation, and evaluation of this project (see pgs 11-13 for details of Contract deliverables):

- Concepts Forward Consulting – will be the assigned Lead Project Manager and will provide case management, full project oversight, financial oversight of sub-contractors and will work closely with Commission staff
- Laurie Hallmark – will offer consultation and legislation expertise as well as county technical assistance as the resident expert on PADs; will enlist a group of trainers to train cohort Counties on the utilization of PADs
- Idea Engineering – will offer strategic consultation and creative direction as a full-service marketing agency (i.e. video direction and production, graphic design, translation, art production and coordination)
- The RAND Corporation – a nonprofit organization utilizing research and analysis for decision making and policy improvement; will provide the staffing for the evaluation of this project
- Peer Organization (to be determined) – will be selected by County cohort to provide input at stakeholder meetings and will be instrumental in the creation of the technology platform, trainings and the usage of the PADs template
- Professional advisement (to be determined) – will contract with an agency in the expert of disability rights, technology and the overall development and implementation of this project; project indicates Professor Peter Blanck of the Burton Blatt Institute at Syracuse may lead this area
- Technology Platform Company (to be determined through discussion with participating counties) – this consultant will be responsible for creation of a secure, private, and voluntary platform where individuals can store their PADs, allowing for access at any given time to be downloaded from a hospital or crisis team or a designated support person

Stakeholder Feedback

All county plans were shared with MHSOAC stakeholders on May 4, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees – four letters from stakeholders were received and will be provided for review (two in support and two in opposition).

The Collaborative included two additional letters of support received from the California Association of Local Behavioral Health Boards and Commissions and NAMI California (**see appendix in original plan**).

Sustainability Plan

All Counties have indicated that they will incorporate lessons learned during this project and hopes PADs implementation can be replicated statewide and in multiple languages. It is the hopes that this project will partner with influential organizations (i.e., NAMI, Disability Rights advocacy groups, etc.) to seek legislation to further promote the utilization of PADs for individuals who may need them.

From: Judy Thomas
To: MHSOAC; Reedy, Grace@MHSOAC
Cc: Susan Keller [redacted]; ksahota [redacted]
Subject: Multi-County Psychiatric Advance Directives (PADs) INN Project
Date: Friday, May 21, 2021 4:21:49 PM

May 21, 2021

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

Re: Multi-County Psychiatric Advance Directives (PADs) Innovations Project

Dear Commissioners:

The Coalition for Compassionate Care of California (CCCC) is supportive of efforts to make psychiatric advance directives (PADs) a standard part of mental health services in California. We are excited about the potential opportunity that the Multi-County PAD Innovation Program Proposal, now under Commission review, presents for making progress toward this goal. We strongly encourage efforts in this arena to build off California's existing infrastructure and leadership related to advance care planning broadly and PADs specifically.

CCCC is a statewide collaboration of consumers, healthcare providers, and policy leaders working together to improve care for people who are seriously ill. Our vision is a world in which people of all ages can live well in the face of serious illness. CCCC works to make conversations about serious illness a normal part of everyday life and palliative care a normal part of healthcare delivery.

Since 1998, CCCC has served as a central hub for advance care planning throughout California. CCCC has a tremendous track record in shaping and changing the standard of practice with respect to advance care planning, including sponsoring legislation, working closely with regulatory bodies, professional education, public engagement, implementation support, quality improvement, research support and electronic documentation and exchange. For example, through CCCC's efforts POLST (portable medical orders during serious illness), which previously did not exist in California, is now a standard part of health care delivery, recognized across the full continuum of healthcare, with more than 1 million POLST forms utilized in California. In addition, CCCC has worked closely with under-resourced populations, including people with developmental disabilities and culturally diverse communities.

CCCC also works closely with local community leaders, including 25 coalitions around the state working to promote advance care planning. Sonoma County has always been an innovator in this field, under the leadership of Susan Keller.

With respect to PADs specifically, in Sonoma County, the Community Network Journey Project, County Behavioral Health, Goodwill Industries, Peer Programs serving Sonoma County, and others have developed the Behavioral Health Advance Care Planning Integration Program (Peer Pilot). A

new Mental Health section was added to the Community Network website to help facilitate training, pilot testing, refinement, and sharing of related resources developed. The Making A Plan-Thinking Ahead Toolkit created by the Peer Pilot also should be considered in furtherance of the Work Plan proposed.

We believe the Multi-County PAD Program would be most successful by collaborating with and building off of these existing turnkey state and local efforts. Collaboration with CCCC and the Community Network to address these concerns is encouraged and would be welcome. Such collaboration could ensure that the ACP perspective is well represented and complimentary efforts optimized concerning mental health parity, whole person care, advance care planning and supported decision making across the continuum of care.

We wholeheartedly support funding and implementation of the PAD Multi-County Collaboration Innovation Plan and request meaningful consideration for issues we raise herein. We hope that the Commission will keep these comments, concerns and suggestions in mind when reviewing and addressing the proposed PAD Innovation Work Plan.

We welcome the opportunity to join in and look forward to the advancement of this important work.

Sincerely,

Judy Thomas, JD

Cc:
Susan Keller
Kiran Shota

JUDY THOMAS, JD
CEO
Coalition for Compassionate Care of California
Office: (916) 779-7500 | Cell: (916) 524-4053
jthomas@CoalitionCCC.org

County of Orange
Health Care Agency, Behavioral Health Services
MHSA Office
405 W. 5th St. Suite 354
Santa Ana, CA 92701

Phone: (714) 834-3104 E-mail: mhsa@ochca.com

Mental Health Services Act Psychiatric Advance Directives - Multi-County Collaborative - Innovation Project

30-Day Public Comment Form- Ending May 23, 2021

PERSONAL INFORMATION			
Name	**Steve McNally**		
Agency/Organization	**Family Advocate/ Family Voice BrainHealth247.org**		
Phone number	[redacted]	**E-mail**	[redacted]
Mailing address (street)	[redacted]		
City, State, Zip	**Costa Mesa**	**CA**	**92627**

MY ROLE IN THE MENTAL HEALTH SYSTEM			
x	**Person in recovery**	☐	**Probation**
x	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

Our Mental Health Journey: I am a family member whose adult son is on disability and conservatorship with a diagnosis of Schizophrenia/ Co-Occurring Substance Abuse Diagnosis. Our restored family relationships result from the Family creating a safe space for recovery and our ill loved one developing the coping skills for the symptoms of his brain illness. Thankfully, my son has been able to access many public resources, which he is just now taking full advantage.

I Am Informed and Support PADS I have attended the four video presentations, each offering slightly views and detail. Attendees raised comments and questions about the project validity, design, and need. Most concurred: PADs are essential, provider awareness and support are lacking, and implementation is an ongoing issue. California is behind other states.

It is clear, today, I can create a psychiatric advance directive or, more simply, add this as part of my advance directive then register online with the California Secretary of State. Currently, I am not aware of anything that stops me; I know how to do this already. Providers have a legal out to not accept all terms of the PAD.

Pg 2/2 S McNally Public Comment **Mental Health Services Act** Psychiatric Advance Directives - Multi-County Collaborative - Innovation Project

I Am Against Approval

- This project is unnecessary to implement PADs in California. Community Planning Funds can demonstrate need and acceptance to scale across the state
- Most project elements, if not all, have already been completed elsewhere. (Duke University Medical Project (2017-2019), Disability Rights CA Handbook (2005), SAMHSA My Mental Health Crisis Plan Application (October 1, 2020).
- The Orange County Project started at $900,000; it is now over $10 million:
    - In April 2020, this project name was one project idea on a list of fourteen projects. In May 2020, it was 3 Years/$950,000.
    - In April/May 2021.it is now a Chorus technology project changing the scope and increasing funding more than 10X.originally presented.
    - As written, there is no guarantee/agreement for participating counties and remaining statewide counties to select Chorus.
- The Chorus portion should be set aside and return as an enhancement for the already funded $24 million technology suite/help@ hand. The community has asked unsuccessfully for accounting and status on this project.
- Many community voices and funding matches are missing:
    - Peer Voices: Access-NorCal-Voices, CAMHPRO, SHARE, CAYEN. -My understanding is that Painted Brain will talk to these groups later.
    - Disability Rights California
    - Correctional Health Funding Matches Through Realignment Funds
    - Both NAMI CA and the California Association of Boards Commissions have expressed support; yet, I wonder if their support reflects on Orange County's inordinate technological funding

- There are more significant needs for innovation funding: SB 803 Peer Certification, SB 855 Parity, Cultural Competency/ Equity--California Pan-Ethnic Health Network (CPEHN) left out of Governor Newsom's May Revise budget.
- A statewide shared funding model would be better for Orange County:
    - Today, without this project, the California Behavioral Health Directors Association (CBHDA) can coordinate a fair share expense model similar to CalMHSA managed statewide project, Each Mind Matters, where Orange County contributes around $900,000.
    - Let's say the total statewide cost was $20 million to bring PADs to scale: Orange County's fair share at @ 8% is $1,600,000, a far cry from @ $13 million. Before introducing Chorus Technology, the May 2020 proposed Orange County participation was $900,000 over three years, similar to the scope as the remaining four participating counties. Public Health represents about 40 percent of the market; the project needs full market participation.

Project Alternative- Greater Upside:

This project is better suited to be a Public/Private partnership as a statewide effort funded on a fair-shared county basis with the California Health and Human Resources co-ordination across key departments: Department of Health Care Services, Department of Managed Care, and California's Office of Statewide Health Planning and Development (OSHPD).

Thank you for the opportunity to offer a public comment. Be Safe Be Well.

Scott, Cody@MHSOAC

To: Reedy, Grace@MHSOAC
Subject: FW: Multi-County Psychiatric Advance Directives (PADs) INN Project

From: Susan Keller [redacted]
Sent: Friday, May 21, 2021 11:24 AM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>
Subject: Multi-County Psychiatric Advance Directives (PADs) INN Project

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

Re: Multi-County Psychiatric Advance Directives (PADs) Innovations Project

Dear Commissioners:

There is great need for the proposed Multi-County PADs Innovation Project now under Commission review. Across the care continuum, an urgent need exists for programs, training and systemic change essential to integrating Advance Care Planning (ACP) into the care of people living with mental health challenges. Here in CA much already has been done that can be built upon in support of work proposed.

We have several concerns that should be addressed. These concerns are grounded in the longstanding broadly supported statewide movement dedicated to improving care of people living with serious illness including mental illness or at the ending of life. For decades now, this Advance Care Planning (ACP) Movement - led by the Coalition for Compassionate Care of CA (CCCC) and the California HealthCare Foundation (CHCF) with support and participation from related institutions, agencies and organizations at the state and local levels – has been dedicated to this mission.

In Sonoma County over the past few years, the Community Network Journey Project, County Behavioral Health, Goodwill Industries, Peer Programs serving Sonoma County and others developed the Behavioral Health Advance Care Planning Integration Program (Peer Pilot). This work was done with support by CCCC, CHCF, the County Health Department and three hospitals serving Sonoma County (Sutter, Kaiser, Providence) among others. Peer community leaders chose to call this work "Advance Care Planning with Mental Health in Mind" rather than have any reference to mental illness. They did so to help reduce stigma and normalize this important work so badly needed. A new Mental Health section was added to the Community Network website to help facilitate training, pilot testing, refinement and sharing of related resources developed.

It is important that the Multi-County PAD Program proposed evolve in a manner that recognizes these turnkey state and local efforts. This is essential in order to build on related expertise, tools, resources and inroads already made here in California. Tapping into this existing work can assist with and support implementation of the Multi-County PAD Innovation Proposal now under review. The Work Plan states that an unmet need existing across the state is the need to: "Align mental health PADs with medical Advance Directives, with a focus on treating the 'whole person' throughout the life course." Yet it seems nowhere is this critical need expanded upon in the Work Plan proposed or included in funding requested. That needs serious consideration.

Collaboration with CCCC and the Community Network to address these concerns is encouraged and would be appreciated. Such collaboration could ensure that the ACP perspective is well represented and complimentary efforts optimized concerning mental health parity, whole person care, advance care planning and palliative care. CCCC has a well-established highly active statewide network of health professionals spanning the health care continuum including a solid network of community based ACP coalitions, and in June will produce the 13th Annual Palliative Care Summit as

leaders in the palliative care field. The Community Network has been a leader for the CCCC and in Sonoma County doing work dedicated to making ACP helpful and doable for people living with mental health challenges of any nature. The Peer Community is well organized and networked around passage and implementation of SB 803 Peer Support Services.

The Sonoma County Behavioral Health ACP Integration Program (Peer Pilot) facilitated by the Community Network has existed since 2016. It came about when a group of county behavioral health clinicians engaged in the Peer Pilot, determined there were no existing Advance Health Care Directives (AHCD) helpful for those they served living with serious mental illness. Since then, the Community Network did extensive PAD research and blended that with knowledge of existing ACP local and state resources. That all resulted in trainings and materials created by the Peer Pilot to address this need. All work was done working with and for the peer community and within existing law governing the use of AHCD here in CA.

The Making A Plan-Thinking Ahead Toolkit created by the Peer Pilot also should be considered in furtherance of the Work Plan proposed. PAD program leadership and trainers could gain a great deal from insights, tools, trainings and lessons learned in the course of Sonoma County Peer Pilot work. The Multi-County PADs Innovation Project should include funding needed for engagement of consultants familiar with the depth and scope of Advance Care Planning work done at the state and local level noted herein.

Please keep these comments, concerns and suggestions in mind when reviewing the proposed Multi-County PADs Innovations Project Work Plan and as you make subsequent decisions to help guide project evolution. Advisory Committees, consultants and trainers employed should include people having a depth of knowledge regarding the nature and accomplishment of the long-standing statewide Advance Care Planning Movement. Peer voices should be well represented and fully integrated across the spectrum of work proposed. Rather than doing the PAD effort proposed as a parallel disconnected effort, it should be done in a manner that dovetails with, builds upon and compliments the great strides made here in California by both the Peer Community and the ACP Movement in this regard.

We wholeheartedly support funding and implementation of the PADs Innovations Work Plan and respectfully request meaningful consideration for issues we raise herein. As a grassroots program dedicated to improving care for this most vulnerable population, we welcome the opportunity to join in and look forward to the advancement of this important work.

Sincerely,

Susan Keller

Susan Keller, MA, MLIS, Program Facilitator and Trainer
Behavioral Health Advance Care Planning Integration Program (Peer Pilot)
Executive Director, Community Network for Appropriate Technologies
Compassionate Care Leadership Award Recipient 2017, Coalition for Compassionate Care of CA

Cc: Peer Pilot Leadership Council (Sonoma County)
Eric Boehm, Peer Support Specialist, Mobile Support Team & Peer Outreach,
Sonoma County/West County Community Services
Kim Barnett, DBA, MS, RN,
Retired Director, Complex Care, the Permanente Medical Group, San Rafael
Erika Klohe, ASW, Community Behavioral Health Lead, Community Health Investment,
Providence, Sonoma County
Teresa "Sid" McColley, RN, CNS, Acute & Forensic Section Manager,
Sonoma County – Department of Health Services – Behavioral Health Division
Michael Reynolds, Peer Programs Coordinator, West County Community Services
Judy Thomas, JD, CEO, Coalition for Compassionate Care of California
Mary-Frances Walsh, MHS, Executive Director, NAMI Sonoma County
Carol West, CHW, PSS, MBBCH, BSc OT, Sonoma County Peer Council

From:	Reedy, Grace@MHSOAC
To:	Reedy, Grace@MHSOAC
Subject:	FW: Public Comment: MHSOAC Psychiatric Advance Directives (PADS) Multi County Collaboration Innovation Plan
Date:	Wednesday, June 2, 2021 11:53:44 AM

From: [redacted]
Sent: Friday, May 21, 2021 5:46 PM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>; Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Subject: Public Comment: MHSOAC Psychiatric Advance Directives (PADS) Multi County Collaboration Innovation Plan

Grace and Commissioners:

I am a family member of an adult son with serious mental illness on a conservatorship living in Costa Mesa, Orange County.

I have attended the three video presentations, each offering slightly views and detail. Attendees raised comments and questions about the project validity and need; I ask the commission staff to review the videos and the transcripts.

I Support PADs

I believe PADs are good and should be commonplace as well as WRAP; however, county and private contractors rarely make consumers/families aware, support, and encourage use on a scaled basis like 75% to 100% of our community has completed. Hospitals and Providers have a legal out as the law is written today,

I Can Do A PAD Today

Currently, I am not aware of anything that stops me from registering an advance directive with a psychiatric feature with the California Secretary of State. I know how to do this already. Providers have a legal out to not accept all terms of the PAD.

Who/ What is Missing:

- Peer Groups- Access-NoprCal, Voices, CAMHPRO, SHARE, CAYEN- have not publically weighed in. My understanding is that Painted Brain will talk to these groups later.
- Disability Rights California
- CBHDA Policy stating all counties support the current implementation of PADs as available today. The acceptance and implementation level for all county clients within both behavioral and correctional health.
- Managed HealthCare, Hospitals, and Large Providers stating their agreement to accept and honor; their current record using the CA Secretary of State

registered advance directives.

- Fair Shared Funding Approach to A Statewide Need; Orange County would be @ 8% or $800,000 for every $10 million
- Correctional Health Funding Matches Through Realignment Funds
- A Greater and More Urgent Focus on State Implementation As Available Now. Proving A Future Case For Legislation As Needed (now in phase 2 at year 4)

I Can Not Support As Presented

I can not support this project; particularly the technology portion at @ $11 million dollars. At best, consider separating the original Fresno proposal expanded to other counties and the Chorus technology into separate decisions. Parity and Peer Certification among other areas are more pressing.

Most project elements if not all have already been completed elsewhere. (Duke University Medical Project (2017-2019) Disability Rights CA Handbook (2005), SAMHSA My Mental Health Crisis Plan App (October 1, 2020). As a group, we could implement available tools today to see if awareness, focus, and priority would increase use and acceptance by providers

Orange County

In April 2020, this project name was one project idea on a list of fourteen projects. In May 2020, it was 3 Years/$950,000. And now we have a Chorus project; let that part of the project stand alone as an enhancement to the ongoing Tech Suite/Help At Hand

Thank You Be Safe Be Well

Have a terrific day!

[redacted]
[redacted]
[redacted]

From:	Skinner, Mary E, ACBH
To:	MHSOAC
Cc:	Reedy, Grace@MHSOAC
Subject:	Public Comment PADS Multi County Collaboration INN Plan for Review
Date:	Friday, May 7, 2021 12:41:20 PM
Attachments:	image001.png

The PADS Multi-County Collaboration project is long overdue. Advance directives have been in use for many years and it is refreshing to see counties taking on the challenge of moving mental health directives forward. There are two very important pieces that I did not see noted in the proposal that could be very useful: New Jersey has a state repository for PADS; and Australia has codified PADS (referred to as advance agreements/advance consent directions) in its Mental Health Act 2015 which went into effect March 2, 2021 https://www.legislation.act.gov.au/a/2015-38/. It is not necessary to reinvent some of the needed wheels.

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AGENDA ITEM 4

Action

June 24, 2021 Commission Meeting

Butte County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of a further $1,252,631 in Innovation spending authority and an additional two years to support a second extension to the Physician Committed Innovation project originally approved by the Commission in 2018 and augmented in 2019.

On May 24, 2018, Butte County received Commission approval of up to $767,900 of innovation spending authority over three (3) years for an innovation project which would promote interagency collaboration related to mental health services, by introducing a new application of a promising practice into an alternative setting. ***This program trains and supports primary care providers in implementing behavioral health screenings for youth into their practice (utilizing the Brief Mental Health Update and Alcohol Screening and Brief Intervention for Youth screenings) and provides intervention and warm hand-offs as appropriate.***

The project started implementation on July 1, 2018. On November 14, 2019, the Commission approved an additional $464,424 to fund 1.0 FTE Clinician and 2.0 FTE Behavioral Health Specialists to cover the increased need for screenings and services as a result of the 2018 Camp Fire.

Butte County is requesting an additional two years and $1,252,631 further Innovation spending authority to meet the high demands from their community and respond to the increased demands because of COVID-19 with no changes to the project goals or purpose. The augmentation would bring the total authorized Innovation expenditure for this project to $2, 484,955 over five years.

Due to the COVID-19 pandemic, the County experienced closure of all schools, and suspension of school athletics, which significantly impacted access to students.

Butte County also reports receiving requests from schools to expand services for more safety-net services for at risk youth which correlates with results of a local focus group indicating that youth are experiencing increased levels of stress, anxiety and depression, lack of opportunities for support, feeling alone and isolated and experiencing pressure to appear “Ok” due to stigma.

The County indicated that this extension would allow the project to include a large group of students not yet reached by the project, who attend alternative schools. Also, the County expressed their interest in piloting the screening with middle school students to be able to identify needs at a younger age and provide supportive services earlier. The

County expects to see increase in needs because of the pandemic and want to be prepared to respond as youth transition back to usual activities over the next year.

The County's offered reasoning for expanding the project to additional students implies that it has found the project to be successful to date, Innovations found to be successful typically are expected to be continued or expanded with other funds.

Commission may wish to ask:

1. **What Learning objectives have been met thus far?**
2. **What Learning objectives have not been met?**

Commission staff raised several additional questions regarding this extension, and those questions and Butte County's responses are included in the staff analysis.

Enclosures (2): (1) Biography for Butte County's Innovation Presenter; (2) Staff Analysis: Physician Committed Extension

Handouts (2): (1) PowerPoint Presentation: Physician Committed Extension; (2) Physician Committed Toolkit

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

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

Name:	Physician Committed
Amount:	Up to $1,252,631 in additional MHSA Innovation funds, to a total authority of $2,484,955
Project Length:	Five (5) years with this Extension

Mental Health Services
Oversight & Accountability Commission

Biography for Butte County Presenter
Physician Committed Project Extension Request

Danelle Campbell, Program Manager

Danelle Campbell is a California Certified Prevention Specialist with over 30 years' experience in the prevention field. She wears multiple hats, one of which is the Program Manager of the Prevention Unit for Butte County Behavioral Health. She provides consultation, facilitation and training at the local, state and national level in areas such as strategic planning, mental health and substance use disorder prevention, family supportive services, and youth development. She has developed four nationally recognized Exemplary Substance Abuse Prevention Award winning programs, is the recipient of the CADCA Coalition of the Year Got Outcomes award and has participated in the Service to Science initiatives. Danelle has developed, implemented and supported the replication of the Committed Programs in schools and communities throughout California. This includes Parent Committed, Merchant Committed and the Committed Chapter model. Danelle brought the first Life of an Athlete Program – Athlete Committed – to California in 2010 and has since replicated that program in over 25 schools throughout California. In 2012, Danelle received two prestigious awards including the California Department of Alcohol and Drug Programs "State Leader in the Field" award and the American Athletic Institute "National Preventionist of the Year" awards.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – Butte County

Innovative (INN) Project Name:	**Physician Committed: Extension Request**
Extension Funding Requested:	**$1,252,631**
Extension Time Requested:	**2 Years (5 years total)**

Review History:

MHSOAC Original Approval Date:	May 24, 2018
Original Amount Requested:	$767,900
Duration of INN Project:	3 Years

First Extension:

MHSOAC Approval Date:	November 14, 2019
Amount Requested:	$464,424
Duration of INN Project:	3 Years

Current Request:

County Submitted Innovation Extension:	May 25, 2021
BOS approval:	June 8, 2021
MHSOAC Consideration of INN Project:	June 24, 2021

Project Introduction:

On May 24, 2018, Butte County received Commission approval of up to $767,900 of innovation spending authority over three (3) years for an innovation project which would promote interagency collaboration related to mental health services, by introducing a new application of a promising practice into an alternative setting. This program trains and supports primary care providers in implementing behavioral health screenings for youth into their practice (utilizing the Brief Mental Health Update and Alcohol Screening and Brief Intervention for Youth screenings) and provides intervention and warm hand-offs as appropriate.

The project started implementation on July 1, 2018, and on November 14, 2019, the Commission approved an additional $464,424 to fund 1.0 FTE Clinician and 2.0 FTE Behavioral Health Specialists to cover the increased need for screenings and services as a result of the 2018 Camp Fire.

Butte County is requesting an additional 2 years and additional funding in the amount of $1,252,631 to meet the high demands from their community and respond to the increased demands as a result of COVID-19 with no changes to the project goals or purpose.

The Need

The original project structure utilized annual athletic physicals as the opportunity for physicians to integrate a behavioral health screening during the appointment. Since then, the project has expanded to utilize the 10th grade hearing/vision screenings as an additional behavioral health screening opportunity. Due to the COVID-19 pandemic, the County experienced closure of all schools, and suspension of school athletics, which significantly impacted access to students.

Butte County also reports receiving requests from schools to expand services for more safety-net services for at risk youth. This request correlates with results of a local focus group indicating that youth are experiencing increased levels of stress, anxiety and depression, lack of opportunities for support, feeling alone and isolated and experiencing pressure to appear "Ok" due to stigma.

In response, the project is expanding to include the primary care community for implementation of their innovation to reach additional youth through additional access points.

The Response

To provide screenings to additional youth during this time of uncertainty, Butte County is requesting to extend this project for an additional two years, bringing the project to the maximum five-year duration. The County is also requesting an additional $1,252,631 to fund the current services and expansion of services to additional sites.

The County indicated that this extension would allow the project to include a large group of students not yet reached by the project, who attend alternative schools. Also, the County expressed their interest in piloting the screening with middle school students to be able to identify needs at a younger age and provide supportive services earlier. The County expects to see increase in needs because of the pandemic and want to be prepared to respond as youth transition back to usual activities over the next year.

Butte County intends on using the additional funding to reach students at the following sites:

- Chico Unified School District alternative high school
- 8th grade students at the hearing/vision screenings
- Primary care clinics, chiropractic clinics, dentist practices and pediatric clinics
- Paradise schools – through athletic physicals and 10th grade hearing/vision screenings

Community Planning Process

Local Level

The issues and the need for additional support for this program was discussed during the Butte Youth Now Coalition in January and February 2021. This Coalition included many

community partners involved in the facilitation and implementation of Physician Committed.

The Butte Glenn Medical Society identified this extension as a critical program for continued implementation and support for the adolescents they serve. Also, Chico Unified School District has expressed their support for the continuation and expansion of the program to include the alternative school sites and the school health aids.

The County's 30-day public comment was held April 12, 2021, through May 12, 2021. The County received one supporting comment that articulated the important services provided to the youth in their community, *"The aftermath of trauma suffered by the Camp Fire, as well as the isolation and stress experienced by youth during the COVID pandemic have only increased the need for this service."*

The County also, received a comment that articulated the need to hire more staff or peers who can provide low level support services while freeing up clinicians to meet the high demand of mental health services in the community. *"If Butte County receives 2,484,955 in funding how will that improve their Mental Health services, if they have a shortage of staff? They are going to need to employ more Behavior Health Case worker or maybe some of the stakeholders can help treat and support the mild to moderate MI's."*

The proposal was reviewed by the MHSA Steering Committee on February 25th, 2021 and recommended the project extension proposal.

Commission Level

This extension was initially shared with the Commission's listserv on May 5th, 2021, and no comments were received. The final version of the extension was then shared with the listserv, stakeholders, and the Commission's Committees (CFLC and CLCC) on May 25th, 2021.

At the date of this writing, no comments were received in response to Commission sharing plan with stakeholder contractors and the listserv.

Learning Objectives and Evaluation

Butte County's evaluation will not change, and the County will continue to promote interagency collaboration related to mental health services and will continue to train and support primary care providers in implementing behavioral health screening for youth into their practice and provide intervention and warm hand-off as appropriate. With this expansion, the County is hoping to identify needs at a younger age and provide supportive services earlier.

Butte County's objectives will not change with this expansion and are defined for the project:

- Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?

- Did the evaluation show that behavioral health screenings were effectively and efficiently integrated into the physical?
- Does this project provide the physician/primary care provider with more confidence and capacity in regard to screening for behavioral health issues?
- Will physicians' comfort levels with discussing behavioral health and adolescents increase with comprehensive training and the implementation of a standardized tool?
- Do adolescents feel more capable of managing early symptoms of behavioral health issues?

The County provided FY 19/20 data showing results from surveys administered to participating physicians and youth. **With the results, is it appropriate to expand the test, or does the County have enough data to transition into a sustainability discussion and integrate the practice into the system of care?**

County Response: *Expansion will allow us to test the screenings and brief intervention with a younger population (8th graders during their hearing/vision screening) and on the alternative school campuses. These are both new settings/situations. In addition, it will allow us to expand into new communities (Paradise, Gridley and Biggs). In addition, the expansion into the orthopedic, dermatologist and orthodontist practices can occur.*

This program has not been able to operate without having to pivot implementation strategies due to unforeseen circumstances that have greatly impacted our local community. Therefore, there is not sufficient, comprehensive data to support that this is a sustainable practice across all sectors identified (schools, primary care providers, ancillary medical providers, etc.) to be imbedded into our system of care.

Alternatively, considering the anticipated decline in MHSA Revenues, it would not be fiscally responsible to incorporate this program into the Prevention and Early Intervention component at this time. All PEI funds are currently encumbered to other projects that address cultural barriers and access and linkage to services, among other strategies. The County is hesitant to decrease funding for these critical strategies during the global pandemic. Due to these funding constraints and without approved funding, the staff currently in the positions identified in the below budget will not be absorbed into another funding stream and are at risk of having their positions defunded at the end of this current Fiscal Year.

In addition, the original project was approved as a county-wide project with a target population and access point including adolescents being seen for annual exams, sports physicals, immunizations, and other standard visits. **It is unclear why Butte County needs additional funding to reach target populations that were included in the originally approved project.**

County Response: *Expansion into other parts of the community was significantly impacted and delayed by local wildfires and COVID-19. As was previously mentioned in prior responses above, the catastrophic natural disasters and COVID-19 pandemic have interrupted this program since its inception. These significant environmental factors have negatively impacted the project's external validity of this research study. With the multiple*

pivots and adaptations that the program has been required to implement, we have not been able to collect sufficient data in a variety of diverse settings to demonstrate effectively that project outcomes would be the same across multiple sectors and settings. Further, internal validity controls are also impacted by the environmental and community impacts of these unforeseen circumstances and disasters as we are collecting data in real time that is directly impacted by anticipated trauma responses from youth in the community. Both of these conditions directly impact the data and research being conducted by this project. Additionally, these conditions also directly inform the relevance of the data, including the subsequent impact on youth and potential identified needs within the target population.

Budget

Funding Source	Year-1	Year-2	**TOTAL**
Innovation Funds	$ 620,834.00	$ 631,797.00	$ 1,252,631.00
2 Year Budget	Year-1	Year-2	**TOTAL**
Personnel	$ 465,078.00	$ 476,041.00	$ 941,119.00
Administration	$ 114,543.00	$ 114,543.00	$ 229,086.00
Operating Costs	$ 15,213.00	$ 15,213.00	$ 30,426.00
Consulting Costs	$ 26,000.00	$ 26,000.00	$ 52,000.00
	$ -	$ -	$ -
	$ -	$ -	$ -
TOTAL:	$ 620,834.00	$ 631,797.00	**$ 1,252,631.00**

The County is seeking authorization to use up to $1,252,631 of additional funding to continue the project for an additional two years. The County states that this request is not expanding the program to more personnel/programmatic expenses. The additional two years of programming will allow for more expansion and evaluation of the program in an environment that is not full of disasters, but rather an environment that can support adequate and effective data and research.

Personnel costs total $941,119 to cover salaries and benefits for the following staff:

- 4.0 FTE Behavioral Health Education Specialist to provide community outreach and collaboration, program education, nurse/physician training, brief intervention with adolescents and warm hand off to clinical navigator when appropriate.
- 1.0 FTE Behavioral Health Clinician Series to provide early intervention services, to non Medi-Cal participants and navigation through local mental health providers.
- Extra Help Peer Provider to inform on program design, program implementation, screening process and linkage to community supports.
- 0.25 FTE Admin Analyst to support data analysis and evaluation of the project. The County estimates spending $48,435 to support the evaluation of this project.

Operating costs total $82,426 including consulting contract and cover program supplies, production of tool kits, screening tools, flyers, educational contracts, physician/medical provider training contract, food for trainings and staff travel/mileage.

Commission staff raised several questions regarding this extension. Those questions and Butte County's responses are included below.

Additional Staff Comments:

The County may wish to explain how the education and medical community are contributing to the overall goal of increasing behavioral health screenings of youth. Are the newly trained physicians able to train their colleagues? Can the Medical Society integrate the training and screening into standard practice?

County Response: *The physicians and nurses trained have had varying levels of comfort in training their colleagues. For some, they have provided training to their colleagues. For others, they have asked us to train additional team members until they feel more comfortable and competent with the process and protocol. With the ultimate goal of integrating the Physician Committed screening and referral process into the medical community screening protocol, we will experience long term systems change. This has already occurred in some of the clinics.*

In addition, it is not common practice or precedent for physicians working in non-acute care hospital settings to provide training and oversite to other peers or colleagues. Typically, those trainings and medical education events occur in teaching hospitals or through Continuing Medical Education Events. Expansion of this project will support further educational support service to physicians working in office-based settings to potentially increase their capacity to provide community based or peer-based training on the project model.

Were the toolkit and training videos produced?

County Response: *Yes*

The County was originally approved to reach adolescents within the entire County. It is unclear why students in alternative high schools or Paradise schools would not have been part of the initial project, or the subsequent extension since they would also receive annual physicals and would have been affected by the Camp fire.

County Response: *The initial pilot project (pre-Innovation) was focused primarily in Chico. Expansion occurred in Oroville right before the Camp Fire (November 2018), however efforts were delayed due to the fire. Efforts in Chico continued as we focused on the expansion to 10th grade hearing/vision screenings and now efforts to expand the screenings are focused on the 8th grade hearing/vision screenings as well. Implementation efforts have also focused on medical providers in the community. Expansion will allow for greater focus on ancillary providers with a significant adolescent population such as dermatologists, orthodontists, and orthopedists.*

The alternative high school campuses do not offer athletic physicals on site, however we are shifting the strategy on these sites to train the school nurses and health aids to administer the screenings next year. This will ensure that those students who visit the school nurse are screened and referred for brief intervention if appropriate.

Paradise schools were significantly impacted by the Camp Fire. Families and students were forced to relocate and most students attended school in a Chico-based warehouse the first year after the fire. As they transitioned back to school in Paradise the following year, attendance was extremely low and they did not offer athletic physicals. This year, we had hoped to integrate the screenings into the athletic physicals and the hearing/vision screenings, however, with COVID-19 neither of those occurred. Paradise is eager for this to happen the next fiscal year. With this extension, we will be able to screen all the high school athletes and all the 10th graders. Given the significant trauma this community has endured, this will be a valuable opportunity to provide brief intervention and referral for long term supportive care to those students.

The County may wish to provide information of how they consulted with youth throughout the pandemic and included youth in the planning discussions for innovation. Have local youth been asked to participate in program development?

County Response: *Youth who participate in the brief intervention sessions complete a brief survey upon the completion of the last session. This feedback provides valuable input and opportunities for program reflection and refinement. We also have a team of Peer Advocates who feedback on program design and experience. In addition, staff consulted with youth on the special accommodations and considerations needed during Covid-19.*

Was there an opportunity to develop additional ideas instead of continued funding of this project?

County Response: *Butte County is working concurrently on a new Innovation Project. This project is currently being designed with stakeholders and will be presented to the Commission in the Fall of 2021.*

Has EPSDT been utilized by physicians and school personnel to offer these screenings? If not, what is preventing EPSDT from being utilized?

County Response: *EPSDT is not a funding stream. EPSDT is an expanded medi-cal benefit only available to full scope medi-cal beneficiaries up to the age of 21 years old. This project currently serves and is proposing to serve all youth in the Butte County area regardless of their payor source or financial status. This includes providing services to youth who may or may not receive or qualify for medi-cal benefits. Furthermore, EPSDT services, i.e., services that are determined to be medically necessary for youth to receive for their qualifying mental health diagnosis, must be determined through a mental health evaluation and assessment, diagnosis, and treatment plan. The Prevention Unit does not provide specialty mental health services or general mental health services to the community, as they are a prevention provider and are unable to provide treatment based on their program design and regulatory standards for prevention services. Additionally,*

most EPSDT services would occur in licensed treatment settings, which excludes schools. Physicians who have already enrolled in the program are likely utilizing traditional medical services codes as the screenings for youth are built into their existing medical care, meaning that these physicians are also receiving the reimbursement for these claims. That reimbursement is not transferred to the Prevention Unit to support operations for the brief intervention and navigation services. Finally, Prevention services, including this project, are designed to provide early intervention to youth prior to entering the treatment system in order to prevent the need for ongoing treatment. All of the youth served by this project would be considered in a pre-consumer or outreach status, where they receive community based early intervention and supports and may be referred through navigation to higher levels of services for ongoing treatment if that is indicated. The treatment providers would then initiate any billing or claiming for services according to the youth's insurance status and benefits, this would not be managed by the Prevention Unit.

The County may also wish to clarify how many physicians have been trained because of this project. Prior to project approval, the County completed a testing phase where 67 physicians were trained on the screening protocol. The FY 19/20 data shows an additional 13 physicians were trained after the project was approved. Is this number accurate? If yes, why is the number lower than the testing phase?

County Response: *The original group of 67 physicians were trained over the three years of the pilot project (pre-Innovation). There was a total of 31 medical professionals trained in 2019, 17 in 2020 and 14 have been trained so far in 2021. These totals include physicians, physician assistants, nurses, and nursing students from CSU, Chico. The number was lower in 2020 due to COVID-19. If expansion is approved, we anticipate another influx in the fall of 2021.*

The funds of this project are subject to reversion on June 30, 2021.

The proposed project extension appears to meet the minimum requirements listed under MHSA Innovation regulations. However, it is unclear that additional Innovation funds are the appropriate source to continue the project.

AGENDA ITEM 5

Action

June 24, 2021 Commission Meeting

Merced County Innovation Plan

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

1. **Transformational Equity Restart Program**

Merced County is requesting up to $3,624,323.39 in Innovation spending authority to address the need to provide mental health services with low barrier access, linkages, and support for those who are justice involved, prior to release. This population tends to have complex needs suffering from mild and moderate, to severe mental illnesses (SMI), and often a complicating comorbidity diagnoses of alcohol and drug addiction, which may lead to a repetitious cycle of justice involved behavior.

The program will focus on reducing barriers and provide access to culturally specific care for those who are justice involved as well as provide important linkages to services by screening incarcerated individuals, complete an assessment of needs and services prior to release, and provide linkage and warm connections to recommended services upon release including mental health services, food insecurity, housing, employment, and transportation.

The County reports that there is a lack of services available and an absence of collaborative efforts within the legal system to specifically address the needs of justice-involved individuals that includes culturally competent care and remediates the potential continuous cycle of jail, hospitalization, food insecurity, alcohol and drug addiction, and homelessness. Connecting this population with appropriate legal, physical, and mental health services is essential and will help to end the seemingly uninterrupted repetitive incarceration cycle.

Merced County intends to provide culturally appropriate and evidenced based services to mitigate recidivism, shorten length of jail sentences, reduce psychiatric hospitalization, and law enforcement involvement. In addition, the program will promote recovery by engaging and collaborating with the justice system to provide diversion programs, problem-solving courts, in-custody treatment programs, reentry support, and post-release supervision.

Merced County wishes to address the cycle of incarceration by reducing barriers and providing linkages to services as well as establishing collaborative service relationships between the legal and mental health systems of care.

The Community Program Planning Process began on January 21, 2021, with a total of eleven (11) focus groups who provided feedback to inform this Innovation Project.

Innovation focus groups were held on March 3, 2021, March 8, 2021, March 30, 2021, and April 7, 2021. ***Two of the meetings were held for justice involved individuals and agencies.***

A public hearing was held virtually on May 4, 2021. The proposed plan was posted for their local 30-day public comment April 1, 2021-April 30, 2021. One public comment was received by the County on April 12, 2021, in support of the project, stating, in part, "Food, water, warmth, sleep, security, safety, healthcare, mental health care, etc. are not a privilege but a human right."

Commission staff originally shared this project with its six stakeholder contractors and the listserv on April 13, 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 June 2, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

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

I am community member and advocate living in Merced County. I support the approval of the Transformational Equity Restart Program because we need more comprehensive care for marginalized communities in this county. As a member of the LGBTQ+ community of Merced County, I have seen firsthand the devastating effects incarceration can have on members of our community. According to data from The National Transgender Discrimination Survey, 1 in 6 trans people have been incarcerated at some point, with those numbers up to nearly half (47%) for Black trans persons. Too often these individuals are subjected to trauma during their incarceration that can have profound impact on their ability to rejoin society. The proposed trainings on cultural humility and focuses on peer support could help create more awareness and understanding of how to treat these persons with respect and create an environment where individuals feel safe enough to access services to better their lives. Providers will need ongoing training on issues that inform the LGBTQ+ experience including chosen family models, gender affirming care, and cultural competency. There will also need to be a plan that allows for confidential feedback to address any injustices in the population served with an action plan to review and correct these behaviors. Thank you for your time and for your consideration. Working toward a better future, LGBTQ+ Collaborative Community Advocate – Merced County

Merced County will hire an outside Research, Evaluation, and Performance outcomes team to evaluate the project and develop, implement, and evaluate the effectiveness of the *Transformational Equity Restart Program,* including completion of the Final Innovation Report.

Commission Staff raised several concerns regarding this proposal and the Commission may wish to ask the following questions:

- ***Describe the development and delivery of culturally specific behavioral health services, including substance use disorders.***
- ***Explain how data sharing between probation, law enforcement, jails, and behavioral health, mentioned in this proposal, will be utilized and/or achieved in this project. No budget item or staff are indicated.***

- ***Describe their sustainability plan.***

- ***Will peers that have justice involvement experience be used in this project, the proposal only identifies peer specialists with lived mental health and/or substance use disorders diagnoses.***

Enclosures (3): (1) Biography for Merced County's Innovation Presenter; (2) Staff Analysis: Transformational Equity Restart Program; (3) Public Comment 04.12.2021

Handout (1): PowerPoint Presentation: Transformational Equity Restart Program

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

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

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

Name: Transformational Equity Restart Program

Amount: Up to $3,624,323.39 in MHSA Innovation funds

Project Length: Five (5) years

Mental Health Services
Oversight & Accountability Commission

Biography for Merced County Presenter
Transformational Equity Restart Program

Jeff Sabean, LMFT, Division Director

Jeff Sabean is a Licensed Marriage and Family Therapist and Licensed Advanced Alcohol and Drug Counselor who has been working in the behavioral health field for over 30 years. He is the Division Director of Merced County's Behavioral Health and Recovery Services, Justice and Community Integration Division where he is responsible for the oversite of the forensic programming for both adult and juveniles.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS—Merced County

Innovation (INN) Project Name:	**Transformational Equity Restart Program (TERP)**
Total INN Funding Requested:	**$3,624,323.39**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**June 24, 2021**

Review History:

Approved by the County Board of Supervisors:	June 22, 2021
Mental Health Board Hearing:	May 4, 2021
Public Comment Period:	April 1, 2021 – April 30, 2021
County submitted INN Project:	March 19, 2021
Date Project Shared with Stakeholders:	April 13, 2021, and June 2, 2021

Project Introduction:

Merced County is requesting up to $3,624,323.39 in Innovation spending authority to address the need to provide mental health services with low barrier access, linkages, and support for those who are justice involved, prior to release. This population tends to have complex needs suffering from mild and moderate, to severe mental illnesses (SMI), and often a complicating comorbidity diagnoses of alcohol and drug addiction, which may lead to a repetitious cycle of justice involved behavior.

The program will focus on reducing barriers and provide access to culturally specific care for those who are justice involved as well as provide important linkages to services by screening incarcerated individuals, complete an assessment of needs and services prior to release, and provide linkage and warm connections to recommended services upon release including mental health services, food insecurity, housing, employment, and transportation.

What is the Problem?

Merced County is trying to address the problem of unsuccessful engagement and barrier accessibility problems for those who are justice involved to receive necessary and culturally appropriate mental health and substance use disorder treatments, following incarceration and upon release to the community. The County reports that there is a lack

of services available and an absence of collaborative efforts within the legal system to specifically address the needs of justice-involved individuals that includes culturally competent care and remediates the potential continuous cycle of jail, hospitalization, food insecurity, alcohol and drug addiction, and homelessness. Connecting this population with appropriate legal, physical, and mental health services is essential and will help to end the seemingly uninterrupted repetitive incarceration cycle.

Merced County currently lacks a comprehensive program between the legal and mental health systems of care that provides specific cultural interventions and strategies to work collaboratively with other justice programs, community-based agencies, advocacy groups, research and educational institutions and members of the community with multi-access points (No wrong door) for the justice-involved population. Instead, justice involved consumers' needs are being addressed through a siloed approach with programs such as Adult Behavioral Health Court, Drug Court, emergency rooms and jails.

To address this treatment void, Merced County's *Transformational Equity Restart Program* was initiated by the community to provide cultural humility, health equity, social justice, and data sharing between probation, law enforcement, jails, and the behavioral health system to treat this population with complex needs that are currently unmet.

Merced County wishes to address the cycle of incarceration by reducing barriers and providing linkages to services as well as establishing collaborative service relationships between the legal and mental health systems of care.

County may wish to describe how this program differs from Merced County's current Triage Program.

How this Innovation project addresses this problem:

Transformational Equity Restart Program will be designed to address the needs of justice-involved individuals by providing the following services:

- Improve care coordination and integration across multiple systems (BHRS, Jail Psychiatric Services, Probation, Courts, etc.)
- Reduce jail and hospital recidivism, reduce time in custody, and reduce overall justice involvement.
- Improve the client and family experience in achieving and maintaining wellness and recovery.
- Improve access to services by offering evidenced-based practices, linkage to housing, peer-support, transportation, and employment services.

Merced County will focus their efforts on addressing the needs assessment of the individuals incarcerated and link them to mental health services upon release. This program will be a referral-based program where the legal system partners will initiate the referrals to the mental health partners. The participants will be referred from existing justice programs (MOU's), including probation, pre-trial services, court, and jail settings. Referrals will also be received from treatment programs, hospitals, and other referrals sources with justice-involved or at-risk individuals.

Proposed programs and services to create multiple access points includes:

1) Jail release: assist with service options upon release.
2) Pretrial Services: Assist with providing options for mental health services and to help with initiating treatment, and support to assist with compliance with court dates.
3) Probation Day Reporting Center: Develop onsite partnerships to assist with referrals, “one-stop shop” model.
4) Probation Supervision: Partner with probation to help with referring clients to services and help reduce probation violations.

An important component in this proposal is for incarcerated individuals to be assessed prior to release. The county may wish to:

1. **Describe which staff will complete the pre-release assessments?**

If other justice-partners are participating in this program and the referrals are not for incarcerated individuals, the county may wish to:

2. **Describe how the assessment process will work and be differentiated from the other programs (Triage, Innovation and/or other established programs within the county)?**

Merced County intends to provide culturally appropriate and evidenced based practices, utilizing bicultural/bilingual staff with lived experience, to provide services to mitigate recidivism, shorten length of jail sentences, reduce psychiatric hospitalization, and law enforcement involvement, by reducing the barriers to provide access to housing, food security, transportation, employment, and peer support services. In addition, the program will promote recovery by engaging and collaborating with the justice system to provide diversion programs, problem-solving courts, in-custody treatment programs, reentry support, and post-release supervision. These services/practices include Motivational Interviewing; Assertive Community Treatment; Harm Reduction; Peer Support Services; Peer Support Certification Program; and the Development of Culturally Specific Interventions.

Merced County estimated the majority (57.7%) of residents are Hispanic (any race), 28.2% as White (non-Hispanic), 3.2 % are African American, and 9.1% are Asian, with reportedly 25 percent of the Merced County jail has people who suffer with serious mental illness.

Merced County states that the population to be served through this proposal includes the justice-involved behavioral health population,18-years and older, people of color, refugees, and LGBTQ.

The proposal states hiring bicultural/bilingual staff but does not identify what threshold languages staff will use. Specifically, County may wish to define their justice involved population and ethnicities in need of services.

Community Planning Process (Pages 14-19)

Local Level

The Community Program Planning Process began on January 21, 2021 with a total of eleven (11) focus groups who provided feedback to inform this Innovation Project and resulted in the following requests: 1) Improve care coordination and integration across multiple systems; 2) Reduce jail recidivism, reduce time in custody, and reduce overall justice involvement; 3) Improve access to services including housing support, medication support services, Behavioral Health, and substance use disorder treatment services; and equitable treatment for all. *More suggestions are in the plan, (pages 17-18).*

Innovation focus groups were held on March 3, 2021, March 8, 2021, March 30, 2021, and April 7, 2021. Two of the meetings were held for justice involved individuals and agencies.

A public hearing was held virtually on May 4, 2021. The proposed plan was posted for their local 30-day public comment April 1, 2021-April 30, 2021. One public comment was received by the County on April 12, 2021, in support of the project, stating, in part, "Food, water, warmth, sleep, security, safety, healthcare, mental health care, etc. are not a privilege but a human right." Please see the attachment for the complete comment. The comment was ***not incorporated*** into the plan but is reportedly documented in the Annual Update.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on April 13, 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 June 2, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

One comment was received in response to Commission sharing plan with stakeholder contractors and the listserv is listed below.

I am community member and advocate living in Merced County. I support the approval of the Transformational Equity Restart Program because we need more comprehensive care for marginalized communities in this county. As a member of the LGBTQ+ community of Merced County, I have seen firsthand the devastating effects incarceration can have on members of our community. According to data from The National Transgender Discrimination Survey, 1 in 6 trans people have been incarcerated at some point, with those numbers up to nearly half (47%) for Black trans persons. Too often these individuals are subjected to trauma during their incarceration that can have profound impact on their ability to rejoin society. The proposed trainings on cultural humility and focuses on peer support could help create more awareness and understanding of how to treat these persons with respect and create an environment where individuals feel safe enough to access services to better their lives. Providers will need ongoing training on issues that inform the LGBTQ+ experience including chosen family models, gender affirming care, and cultural competency. There will also need to be a plan that allows for confidential feedback to address any injustices in the population served with an action plan to review and

correct these behaviors. Thank you for your time and for your consideration. Working toward a better future, LGBTQ+ Collaborative Community Advocate – Merced County

Learning Objectives and Evaluation:

Merced County identified six primary learning goals:

1.) Behavioral Health Outcomes: The Transformational Equity Restart Program will improve behavioral health outcomes for justice involved individuals and families by offering culturally specific treatment options.
2.) Access: By providing culturally specific and responsive programs, we will improve access to behavioral health services for justice involved individuals and families in the community.
3.) Capacity Building: We will increase collaboration by developing multiple access points (No wrong door) and assisting clients with warm hand-off's as they transition from the jail setting back into the community, while increasing therapeutic interventions for wellness and recovery.
4.) Culturally Specific Programming: This program will test if culturally appropriate services mitigate recidivism, psychiatric hospitalization, and law enforcement contact by providing connections to housing, employment, culturally appropriate treatment, and peer support services in the community.
5.) Development of Culturally Specific Interventions: The TERP program will increase culturally specific interventions by working with the program staff, the evaluator, and program participants to develop and adapt culturally specific interventions for the Merced County justice involved individuals and families.
6.) Peer Support Certification Program: To reduce recidivism, build upon lived experience, and foster hope for participants of the program, they will have the opportunity to participate in the peer support certification program as a pathway to future employment and career opportunities.

Merced County will hire an outside Research, Evaluation, and Performance outcomes team to evaluate the project and develop, implement, and evaluate the effectiveness of the *Transformational Equity Restart Program,* including completion of the Final Innovation Report.

Merced County states that "as the program develops, multiple access points from the justice system, a logic model will be assembled to ensure each access point is put in the correct context as the entry point into the Transformation Equity Restart Program". Since justice involvement is complex and has numerous entry points, the counties work to develop a system and align data resources will assist creating useful comparison group," (Page 17).

Merced County's data collection includes:

- Demographics, gender, ethnicity, age, etc.
- Number of trainings and consultations provided include topics
- Total length of time client is open to the program
- Number of clients receiving behavioral health treatment from the program
- Number of clients linked to behavioral health services in the community

- Number of clients with a reduction in mental health symptoms
- Number of clients who report improved physical health
- Number of clients who have been provided linkage to ongoing treatment for mental health
- Number of clients who reported improved ability to access services in the community
- Number of clients who report services provided respected their culture, traditions, norms, beliefs, and values
- Number of clients who report improved quality of life
- Number of clients who reported high satisfaction with the program services
- Data collection methods will be tasked to the program
- Data will be collected during each encounter

Merced County may wish to identify the number of people to be served and if they are collecting qualitative data.

Budget

Merced County is seeking authorization to use up to $3,624,323.39 in MHSA Innovation funding for this project over a period of five (5) years. Merced County has an "estimated" $2,976,538.93 in Innovation Funds that are subject to reversion on June 30, 2021.

Funding Source	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Innovation Funds	**$729,645.14**	**$696,734.49**	**$714,336.52**	**$732,466.62**	**$751,140.62**	**$3,624,323.39**
Personnel	$292,271.20	$309,360.55	$326,962.59	$345,092.68	$363,766.68	$1,637,453.71
Personnel/ Direct Costs	$277,373.94	$277,373.94	$277,373.94	$277,373.94	$277,373.94	$1,386,869.68
Operating Costs	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$50,000.00
Non-recurring Costs	$50,000.00	None	None	None	None	$50,000.00
Evaluation	$100,000.00	$100,000.00	$100,000.00	$100,000.00	$100,000.00	$500,000.00
Total	$729,645.14	$696,734.49	$714,336.52	$732,466.62	$751,140.62	$3,624,323.39

- Personnel costs total $ 1,637,453.71 (46% of total funding) and includes:
  - .50 FTE Program Manager
  - 1.00 FTE Mental Health Clinician
  - 1.00 FTE Dual Diagnosis Specialist
  - 2.00 FTE Peer Support Specialist (with lived Mental Health and /or SUD, does not state justice-involved)
  - Program Evaluator (Consultant/Contracted)

- Direct Personnel Operating Costs –Benefits
  - $1,386,869.68 (38%)

- Direct Costs – Operational (5-Year Total $50,000 – 1%)
    - Operating Expenses include but are not limited to:
        - Office rent
        - Client Expenses (bus passes, incentives, etc.)
        - Program supplies/materials for classes/presentations
        - General office supplies
        - Food and snacks for classes/presentations
        - Staff development and training
        - Cell phone and telephone for staff
        - Insurance expense
        - Transportation costs for travel staff for outreach, meetings, trainings. Etc.
        - Advertising for the project

- Non-Recurring Costs $50,000 (1%)
    - Desktops/Laptops $20,000
    - Vehicle -one $30,000

- Consultant Costs / Contracts
    - $500,000.00 (14%)

County may wish to clarify the funding; 84% of the funding is for staffing and 14% for the contractor/evaluator, totaling 98% of the budget. County may wish to describe how culturally specific strategies will be funded once developed.

County may wish to address Peer Certification Program logistics, who will conduct the training, where it will be held, and how it will be funded. This is not addressed in the budget.

Additional Questions that the Commission may wish to ask the County:

- ***Describe the development and delivery of culturally specific behavioral health services, including substance use disorders.***
- ***Explain how data sharing between probation, law enforcement, jails, and behavioral health, mentioned in this proposal, will be utilized and/or achieved in this project. No budget item or staff are indicated.***
- ***Describe their sustainability plan.***
- ***Will peers that have justice involvement experience be used in this project, the proposal only identifies peer specialists with lived mental health and/or substance use disorders diagnoses.***

Merced County – Email received during County Public Comment on 4/12/21

"Hiring more Mental health staff: Youths in Juvenile Hall are in need of mental health services. This vulnerable population is often underserved. Can MHSA or BHRS Merced County hire more mental health clinicians and mental health workers to support youth/clients in Juvenile Hall/Prisons?

Incarceration Peer Advocates: Currently, there are no Incarceration Peer Advocates at Juvenile Hall hired by BHRS Merced County. There is a need for Incarceration Peer Advocates to be stationed at Juvenile Hall. It is important that Incarceration Peer Advocates have lived experience of being once incarcerated. Empathy is important for mental health, empowerment, and healing. An Incarceration Peer Advocates on the treatment team is important because they provide an insightful perspective that Mental Health staff do not have on every service (Individual therapy, Group therapy, case management, grievance, etc.).

Case Manager: Poverty is an indicator of crime. Youths at Juvenile Hall often come from poverty and broken homes. It is important for youths at juvenile hall to have a case manager hired by BHRS Merced County. A case manager would teach the youth how to apply for jobs, how to keep a job, how to apply for a driver's license, how to find housing, how to get a bus pass and use public transportation, how to apply for applicable welfare programs, how to apply for college, how to apply for financial aid, provide sexual health education information, and help youths register to vote. The case manager(s) would assist the youths while they are at Juvenile Hall. Can MHSA hire a case manager for the youths who enter Juvenile Hall? It is important to uplift youths out of poverty and provide them the necessary resources to rehabilitate them into the community.

Stigma: Juvenile Hall staff and mental health staff often utilizes stigmatizing terminology to describe the youths. There is a need to prevent mental health staff from using stigmatizing words to describe youths at Juvenile Hall. It is important to humanize youths.
a. Most stigmatizing words: bad, criminal, dangerous, detainee, just a gang member, just a drug user, convict, prisoner, delinquent, offender, villains, them, and arrestee.
b. Somewhat stigmatizing words: minors, kids, clients, Title 15, forensics, and minor who is detained.
c. Humanizing words: youth, community member, member, and participant.

Advocating for youth through the Maslow's hierarchy of needs: The Maslow's Hierarchy of needs explain the basic human needs need to be met in order to achieve good mental health and a thriving life. Can MHSA advocate for youth at Juvenile Hall and ensure youth at Juvenile Hall to have safety, quality sleep, quality food, quality water, quality education, clean and humane living area, to be warm, quality healthcare services, and quality mental health services? Youth at Juvenile Hall sometimes do not have safety, quality sleep (due to cold temperature, not having a 2nd blanket, not having a sweater, or having the light in the cell left on at night), quality food, quality water (youth often say water from the water fountain in the cell is not good), sometimes youth are cold, and sometimes youth do not receive enough mental health services.

In the 1980's to the 1990's, there was a "tough on crimes" concept that promoted the idea that people who were incarcerated should be punished by low quality of food, water, warmth, sleep, living conditions, etc. But how can we rehabilitate or achieve recovery through mental health when the basic human needs are not met? Food, water, warmth, sleep, security, safety, healthcare, mental health care, etc. are not a privilege but a human right."

AGENDA ITEM 6

Action

June 24, 2021 Commission Meeting

Humboldt County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Humboldt County's request to expend up to $1,617,598 in MHSA Innovation funds over five (5) years in support of the Resident Engagement and Support Team (REST) innovation project.

REST is designed as a complement to Humboldt County's previous innovation project, Housing, Outreach and Mobile Engagement (HOME). HOME successfully tested a housing-first model aimed at sheltering chronically homeless and unhoused consumers and supporting them to reach a degree of stability.

Through the evaluation of the HOME program, the County learned that:

- Peer coaches increase engagement of clients and help them reach their goals.
- Collaboration with local homelessness services agencies can result in increases in affordable housing.
- Partnering with law enforcement to identify and engage individuals experiencing homelessness is a successful strategy.
- The maintenance of housing for newly housed consumers is an area of need.
- The definition of "stability" varies, and stability goals must be individualized.

Successful components of HOME are being continued with social services funding and will remain part of the Humboldt Housing and Homeless Coalition (HHHC) Continuum of Care. The identification of the maintenance period as an area of need and opportunity for further support to prevent individuals from re-entering homelessness is in alignment with the community planning process for the MHSA 2020-2023 three-year plan which ranked providing more housing and supportive services as a top priority.

The community planning process and lessons learned from the HOME evaluation resulted in the creation of the REST Innovation proposal. REST is a "Post-Housing" Housing First model that will test whether assigning case managers and peer coaches to consumers will help them maintain their housing. The three main goals of the project are:

- To have a seamless transition for consumers once they are housed to allow them to fully engage in Outpatient Behavioral Health Services.
- To continue to refine the services offered to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice.
- Improve housing stability for community residents as a component of the HHHC Continuum of Care, which is comprised of organizations, providers, developers,

government agencies, faith-based organizations and community members dedicated to ending homelessness.

Presenters for Humboldt County's Innovation Project:

- Jack Breazeal, LMFT, Deputy Director, Humboldt County Behavioral Health Adult System of Care

Enclosures (2): (1) Biography for Humboldt County's Innovation Presenter; (2) REST Staff Analysis.

Handout (1): PowerPoint Presentation.

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

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

Proposed Motion: The Commission approves Humboldt County's Innovation Project, as follows:

Name:	**Resident Engagement and Support Team (REST)**
Amount:	**Up to $1,617,598 in MHSA Innovation funds**
Project Length:	**Five (5) Years**

Mental Health Services
Oversight & Accountability Commission

Biography for Humboldt County Presenter
Resident Engagement and Support team (REST)

Jack Breazeal, LMFT

Jack Breazeal has worked in County Behavioral Health systems for over fifteen years. Jack started providing Mental Health crisis evaluations for minors in Riverside County, and after moving to the Bay Area, continued providing crisis evaluations for the City and County of San Francisco. Eventually, Jack moved to Lake County Oregon and worked his way up from a clinician to Director of Behavioral Health. Jack also operated a private practice for many years, always feeling the more he moved to Administration, the more he felt a need to continue providing therapy, his first love. Jack had an opportunity to move back to California and live on the coast in Del Norte County. Jack ran the operations for Behavioral Health and became familiar with Mental Health Services Act as, in addition to many other hats, he was the MHSA coordinator. Jack then took an opportunity to promote in Humboldt County and has served as the Deputy Director for Humboldt County Behavioral Health Adult System of Care for the past year and a half.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS—Humboldt County

Innovation (INN) Project Name:	**Resident Engagement and Support Team (REST)**
Total INN Funding Requested:	**$1,617,598**
Duration of INN Project:	**Five (5) years**
MHSOAC consideration of INN Project:	**June 24, 2021**

Review History:

Approved by the County Board of Supervisors:	Pending
Mental Health Board Hearing:	May 27, 2021
Public Comment Period:	April 26, 2021-May 27, 2021
County submitted INN Project:	June 2, 2021
Date Project Shared with Stakeholders:	June 2, 2021

Project Introduction:

Humboldt County is requesting up to $1,617,598 of Innovation spending authority to test whether assigning case managers and peer coaches to consumers, who recently became housed, will help them maintain their housing.

The three main goals of the project are:

- To have a seamless transition for consumers once they are housed to allow them to fully engage in Outpatient Behavioral Health Services.
- To continue to refine the services offered to consumers once housed to ensure these services follow the principles of the Housing First model and fidelity to the Housing First practice.
- Improve housing stability for community residents as a component of the Humboldt Housing and Homeless Coalition (HHHC) Continuum of Care, which is comprised of organizations, providers, developers, government agencies, faith-based organizations and community members dedicated to ending homelessness.

What is the Problem?

Humboldt County identifies that they have achieved some success in developing a system for finding housing for individuals experiencing homelessness both through their previous innovation project, Housing, Outreach and Mobile Engagement (HOME) and through regular, strategic collaboration with Humboldt Housing and Homeless Coalition

(HHHC) as part of their continuum of care. HOME successfully tested a housing-first model aimed at sheltering chronically homeless and unhoused consumers and supporting them to reach a degree of stability.

As a result of the HOME program, 224 individuals were supported to obtain housing. The County provides data showing that 66% percent of people who obtained housing through HOME, remained housed after two years, with 16% returning to homelessness. HOME data incudes "move out reasons" and the data shows that the primary reason for consumers being asked to leave was for being too disruptive. **The County surmises that being disruptive can be attributed to ongoing mental health needs not yet addressed and in need of ongoing support with Behavioral Health services.**

Through the evaluation of the HOME program, the County learned that:

- Peer coaches increase engagement of clients and help them reach their goals.
- Collaboration with local homelessness services agencies can result in increases in affordable housing.
- Partnering with law enforcement to identify and engage individuals experiencing homelessness is a successful strategy.
- The maintenance of housing for newly housed consumers, is an area of need.
- The definition of "stability" varies, and stability goals must be individualized.

Successful components of HOME are being continued with social services funding and will remain part of the HHHC Continuum of Care. ***The identification of the maintenance period as an area of need and opportunity for further support to prevent individuals from re-entering homelessness, aligned with the community planning process for the MHSA 2020-2023 three-year plan which ranked providing more housing and supportive services as a top priority.***

The County is seeking approval authority to test an approach to prevent those 16% from returning to homelessness as well as other individuals who were recently housed following crisis interventions, other referrals, or connections through full-service partnerships.

To highlight the overlap between homelessness and mental illness, the County provides data from the 2019 Point in Time Count, of those experiencing homelessness, identifying 337 people reported having a diagnosis of severe mental illness. In addition, the Coordinated Entry System shows 227 out of 302 people, who are chronically homeless, identify as having a mental health disability. These numbers not only show that mental health needs of those experiencing homelessness but also show the continuing need for housing solutions.

How this Innovation project addresses this problem:

Humboldt County identifies REST as an extension of the Housing-First model successfully tested through the HOME program. Calling it a "Post-Housing" Housing First model, the REST project will assign case managers and peer coaches to the Adult Outpatient Program to serve consumers, age 18 and older, who do not meet the level of care required for Full-Service Partnership (FSP) services. The County hopes that this

additional service will support consumers to maintain housing and more successfully engage with outpatient behavioral health services.

Referrals to REST will be of consumers who are homeless or at risk of becoming homeless and may include folks stepping down from HOME or FSP services, consumers leaving crisis care, or those already connected to Adult Outpatient Services.

Case managers and peer coaches will work with consumers to help them maintain their housing by providing individualized support that may include creating a structured routine for activities of daily living, linkages to physical and mental health services, coordination with other agencies, problem solving with landlords, working collaboratively with family or other supports, and helping consumers develop additional coping skills in support of their housing and wellness goals.

The County is aware of San Joaquin County's Progressive Housing project as it an also an adaptation of the housing-first model. The County also looked into Merced County's Housing Supportive Services Program and San Francisco County's Intensive Case management/ FSP to Outpatient Transition Support Project. The County acknowledges similarities and will incorporate learnings from the other counties into the REST project but also maintains that REST offers a unique solution to support consumers to remain housed and increase mental health stability as part of their overall continuum of care.

Community Planning Process (see pages 14-15 in full plan for more details)

Local Level

The County initiated their three-year planning process for the MHSA 2020-2023 plan and received over 700 responses from surveys and stakeholder meetings.

- Providing housing and supportive services was ranked as a top priority.
- Continuity of care of individuals following discharge from the hospital, crisis services and jail also ranked as top priorities.
- Serving persons experiencing homelessness was ranked as the number one population not being adequately served by current MHSA programs.

The County also held stakeholder meetings for the 2020-2021 Annual Update where stakeholders continued to identify homelessness as a top priority at four separate meetings and through one written comment.

Community feedback resulted in the development of the REST proposal.

The proposed Innovation plan was posted for 30-day public comment on April 26, 2021 through May 27, 2021. The proposal will be considered by the County's Board of Supervisors in June 2021.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on April 27, 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 June 2, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

At the date of writing, no comments were received in response to Commission sharing plan with stakeholder contractors and the listserv.

Learning Objectives and Evaluation:

The County hopes to serve 100 individuals annually for a total of 500 served over the course of the five-year project. The County has identified six learning questions that will be evaluated with data collected through various sources, including: Electronic Health Record (Avatar), reports from the DHCS Data Collection and Reporting (DCR) System, reports from the HOME database, and reports from Activate Care, data on physical health appointments and contacts as well as emergency room and Urgent Care appointments, data obtained from the North Coast Health Improvement and Information Network (NCHIIN) Health Information Exchange (HIE), data gathered from consumers through the Consumer Perception Survey, and a survey with local landlords will also be conducted annually. The County will also do comparative analysis with data they have already collected from the HOME program.

The six learning questions are:

1. How effective is ongoing case management and peer support for those discharged from SV or CSU, or exiting from a Full-Service Partnership (FSP) or HOME services, to maintain housing?
    a. The County hypothesizes that well-trained Case Managers and Peers will increase engagement of consumers in appointment-based outpatient care.
2. Will increased case management and peer support services facilitate recovery as indicated by a reduction in the number of emergency service episodes?
    a. The County hypothesizes that consistent and consumer driven interventions by our REST team will promote successful outcomes leading to appropriate and sustained transitions to lower levels of care and reduced need for emergency psychiatric care.
3. Will educating landlords about recovery increase the number of landlords who accept our consumers as tenants?
    a. The County hypothesizes that their education efforts with local landlords will lead to increased capacity for housing as well as forbearance for consumers as they actively engage in treatment services.
4. Will REST help the County learn what services and supports are most utilized by newly housed individuals?
    a. The County hypothesizes that by using consumer driven treatment approaches that are individualized for the consumer that clients will maintain treatment compliance.
5. Will REST services contribute to improved physical health outcomes for consumers served?
    a. The County hypothesizes that their efforts to ensure long term housing stability will contribute to the overall physical health of our clients.
6. How long do consumers remain housed?

a. The County hypothesizes that given the interventions that the REST program proposes they will see a much higher rate of consumers remaining housed.

The Budget

Funding Source	Year-1	Year-2	Year-3	Year-4	Year-5	**TOTAL**
Innovation Funds	**$ 300,196.00**	**$ 314,832.00**	**$ 324,955.00**	**$ 335,339.00**	**$ 342,276.00**	**$ 1,617,598.00**
Medi-Cal FFP*	$ 166,826.00	$ 166,826.00	$ 166,826.00	$ 166,826.00	$ 166,826.00	$ 834,130.00
5 Year Budget	Year-1	Year-2	Year-3	Year-4	Year-5	**TOTAL**
Personnel*	$ 440,606.00	$ 454,645.00	$ 464,128.00	$ 474,096.00	$ 480,594.00	$ 2,314,069.00
Administration	$ 8,373.00	$ 8,671.00	$ 8,991.00	$ 9,199.00	$ 9,418.00	$ 44,652.00
Evaluation	$ 4,814.00	$ 5,112.00	$ 5,432.00	$ 5,640.00	$ 5,859.00	$ 26,857.00
Operating Costs	$ 13,230.00	$ 13,230.00	$ 13,230.00	$ 13,230.00	$ 13,230.00	$ 66,150.00
	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL:	$ 467,023.00	$ 481,658.00	$ 491,781.00	$ 502,165.00	$ 509,101.00	$ 2,451,728.00
*The County has been notified that the budget calculations are off by a couple of dollars.						
As the calculations are estimates, this is not a significant issue.						

The County is requesting authorization to spend up to $1,617,598 in MHSA Innovation funding for this project over a period of five (5) years consisting of personnel expenses, direct and indirect costs. The County will also utilize an estimated $834,132* in Medi-Cal Federal Financial Participation funding bringing the total investment to $2,451,730*.

- Personnel costs total $2,314,069 to cover the salaries and benefits for the following staff:
  - 1.0 FTE Program Coordinator
  - 2.0 FTE Mental Health Case Managers
  - 2.0 FTE Peer Coaches I/II
- Administration costs total $44,652 to cover salaries and benefits for the following staff:
  - .02 FTE Program Manager
  - .05 FTE Administrative Analyst I/II
- Evaluation costs total $26,857 to cover salaries and benefits for the following staff:
  - .05 FTE Administrative Analyst I/II.
- Operating costs total $66,150 and covers the expenses of laptops and cell phones for direct services project staff, Activate Care licenses, cell phone charges, and rental assistance for clients in the REST program.

The County may decide to contract out the project based upon cost-saving strategies. At the time of consideration by the Commission, the County has not decided and would like the proposal to be reviewed as though it will be implemented by the County.

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

AGENDA ITEM 7

Action

June 24, 2021 Commission Meeting

Imperial County Innovation Plan

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

1. **Holistic Outreach Prevention and Engagement (HOPE)**

Imperial County is requesting up to $3,455,605 of Innovation spending authority to provide holistic treatment options following a psychiatric emergency for youth and young adults, ages 13-25.

The County is designing a program to engage youth and young adults with more holistic and specialized services as well as by hiring Transitional Aged Youth (TAY) Peer Support Specialists who will be assisting clients to navigate services, providing support, and promoting self-advocacy, which will lead to better quality of care and improved outcomes, and will assist with reducing stigma and increase participation by this population.

The County reports that despite initiating and expanding their Crisis Co-Response Team (CCRT) between the behavioral health department and law enforcement agencies, providing services in both the Mental Health Triage Unit and through outpatient clinics increased enrollment, follow up activities and treatment compliance by youth in crisis has not occurred.

The CCRT is designed to "resolve immediate concerns, ensure safety, and engage individual into outpatient treatment services" (page 4). **The CCRT is not designed to engage, ensure, or provide follow up to youth and young adults for them to utilize suggested follow up activities, nor is it designed to address stigma that may be associated with crisis intervention or motivate youth to participate in ongoing preventative services.**

The County proposes to adapt its current practice of providing outreach and engagement, and referrals for follow up mental health services and design a program, Holistic Outreach Prevention and Engagement, (HOPE). HOPE will be focused on wellness activities including mindfulness, fitness, music/art, to bring a balance of emotional, physical, spiritual, and mental health. These modalities are intended to facilitate engagement as well as help reduce the stigma associated with receiving mental health services.

An integral part of this program will be the hiring of TAY (18 years or older) peers who will serve as both navigators and role models for participants' mental health recovery. HOPE staff will be embedded in each of the current systems' discharge processes, (CCRT,

Mental Health triage Unit and Outpatient Clinics) and will work collaboratively within these programs and the participant to develop a client driven wellness plan.

The County proposes that the introduction of Peers at the discharge planning stages of any of its current crisis and service levels will serve to:

1. act as a role model for recovery,
2. provide a warm handoff to help mitigate stigma associated with mental health,
3. provide navigation to supplemental services, and
4. introduce other more youth friendly modalities (exercise, yoga, meditation, nutrition, music, art) as well as provide an empowerment process to youth to decide in which modalities to participate.

The County hopes to determine if using this two-level approach (Peers and holistic treatment activities) will motivate youth and older youth to participate in mental health services, reduce psychiatric emergencies and reduce the current "no show" rate as well as stigma associated with the services.

Imperial County conducted an extensive Community Program Planning Process (CPPP) in February and March 2021 via zoom. A total of sixteen CPPP Zoom forums were conducted, eight (8) in English and eight (8) in Spanish.

Imperial County received 389 surveys (69 of which were from the age groups of 16 to 25) from stakeholders and community members. The results identified that the essential target population that indicated the greatest need was for youth and young adults, between the ages of 13-25.

Commission staff originally shared this project with its six stakeholder contractors and the listserv on May 5, 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 June 2, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

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

Enclosures (2): (1) Biography for Imperial County's Innovation Presenter; (2) Staff Analysis: Holistic Outreach Prevention and Engagement

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

https://mhsoac.ca.gov/sites/default/files/Imperial_INN_HOPE_1.pdf

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

Name: Holistic Outreach Prevention and Engagement

Amount: Up to $3,455,605 in MHSA Innovation funds

Project Length: Three (3) years

Imperial County
Presenter Biography

Brenda Sanchez, MPA

Brenda is a resident of Imperial and obtained a B.A. in Psychology from San Diego State University and a Master Degree in Public Administration from National University. She has worked for Imperial County Behavioral Health Services (ICBHS) for 16 years. Since 2004, she worked primarily in the Children and Adolescent unit in different capacities. Her past positions include Mental Health Rehabilitation Technician, Mental Health Rehabilitation Specialist, Program Supervisor and Behavioral Health Manager. She is currently a Deputy Director of Behavioral Health Services and oversees the operation of clinics and programs under the Youth and Young Adults Division. This includes a variety of programs including one school-based program, 2 Family Resource Centers, and 3 regional clinics providing outpatient and Full Service Partnership services.

Brenda's work at Imperial County Behavioral Health has focused on improving outcomes for children, youth and young adults with mental health challenges and their families. She is passionate about promoting services that are strength-based, client-centered and client-driven in order to empower individuals overcome their mental illness and achieve recovery. Brenda has been instrumental in the selection and implementation of programs and evidence-based models to meet the specific needs of our community.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – Imperial County

Innovation (INN) Project Name:	**Holistic Outreach Prevention and Engagement (HOPE)**
Total INN Funding Requested:	**$3,455,605**
Duration of INN Project:	**3 Years**
MHSOAC consideration of INN Project:	**June 24, 2021**

Review History:

Approval by the County Board of Supervisors:	Pending Commission Approval
Mental Health Board Hearing:	June 1, 2021
Public Comment Period:	May 1, 2021 – May 31, 2021
County submitted INN Project:	April 30, 2021
Date Project Shared with Stakeholders:	May 5, 2021 and June 8, 2021

Project Introduction:

Imperial County is requesting up to $3,455,605 of Innovation spending authority to provide holistic treatment options following a psychiatric emergency for youth and young adults, ages 13-25.

Although the County has tried numerous methods to reach out to youth and young adults to engage them with mental health treatment and follow up, current methods have not been effective. The County is designing a program to engage youth and young adults with more holistic and specialized services as well as by hiring Transitional Aged Youth (TAY) Peer Support Specialists who will be assisting clients to navigate services, providing support and promoting self-advocacy, which will lead to better quality of care and improved outcomes (page 6) and will assist with reducing stigma and increase participation by this population.

What is the Problem?

The County reports that despite initiating and expanding the Crisis Co-Response Team (CCRT) between the behavioral health department and law enforcement agencies, providing services in both the Mental Health Triage Unit and through outpatient clinics increased enrollment, follow up activities and treatment compliance by youth in crisis has not occurred. Prior to developing the CCRT, the County reports that in FYs 18/19 and 19/20, 32% and 26%, respectively, of the crisis admissions were youth and young adults

(page 2). Although the County reports fewer admissions in FY 19/20, it reports that the mental health conditions were more acute (page 3), and the majority of these clients were not already participating in any mental health services with the County and were reported as "inactive clients." During these same fiscal years, the County reports "no show rates" ranging between 25-34% for services related to intake, initial nursing assessment, initial psychiatric assessment, and psychotherapy.

As discussed above, the County and local law enforcement established a pilot program, the Crisis Co-Response Team (CCRT). Since its inception 8 months ago, the CCRT has received 50 calls, six (6) of which were for youth and young adults. The CCRT is designed to "resolve immediate concerns, ensure safety, and engage individual into outpatient treatment services" (page 4). **The CCRT is not designed to engage, ensure, or provide follow up to youth and young adults for them to utilize suggested follow up activities, nor is it designed to address stigma that may be associated with crisis intervention or motivate youth to participate in ongoing preventative services.**

How this Innovation project addresses this problem:

The County proposes to adapt its current practice of providing outreach and engagement, and referrals for follow up mental health services and design a program, Holistic Outreach Prevention and Engagement, (HOPE). HOPE will be focused on wellness activities including mindfulness, fitness, music/art, to bring a balance of emotional, physical, spiritual, and mental health. These modalities are intended to facilitate engagement as well as help reduce the stigma associated with receiving mental health services.

An integral part of this program will be the hiring of TAY (18 years or older) peers who will serve as both navigators and role models for participants' mental health recovery. HOPE staff will be embedded in each of the current systems' discharge processes, (CCRT, Mental Health triage Unit and Outpatient Clinics) and will work collaboratively within these programs and the participant to develop a client driven wellness plan.

Prior to working with this population, Peers will participate in a support training that will show them how to use their own experiences to help youth and young adults. Peers will also receive an orientation and training on County mental health services and their specific roles as a member of this treatment team. They will also be provided supervision by a program supervisor who will evaluate their performance, provide guidance and support.

Imperial County has reviewed other county programs, (Mendocino, San Diego, Alameda, Shasta, Ventura, Fresno, Glenn, and San Luis Obispo), and has discovered that none of them are currently using the combination of a peer driven, holistic approach as an engagement strategy for youth and young adults who have had a psychiatric emergency. (See page 9 of the Innovation proposal for a complete list of the Counties and their respective programs and program descriptions).

The County proposes that the introduction of Peers at the discharge planning stages of any of its current crisis and service levels will serve to 1) act as a role model for recovery,

2) provide a warm handoff to help mitigate stigma associated with mental health, 3) provide navigation to supplemental services, and 4) provide introduction to other more youth friendly modalities (exercise, yoga, meditation, nutrition, music, art) as well as provide an empowerment process to youth to decide in which modalities to participate.

The County hopes to determine if using this two-level approach (Peers and holistic treatment activities) will motivate youth and older youth to participate in mental health services, reduce psychiatric emergencies and reduce the current "no show" rate as well as stigma associated with the services.

Community Program Planning Process (Pages 14-21)

Local Level

Imperial County conducted an extensive Community Program Planning Process (CPPP) in February and March 2021 via zoom. A total of sixteen CPPP Zoom forums were conducted, eight (8) in English and eight (8) in Spanish. The presentation slides provided during the zoom meetings offered guidelines and defined the essential purpose on innovation projects and funding. A link to survey monkey was provided to further encourage multi-modal participation. The meeting as well as the plan (after it was developed) were advertised in three (3) local newspapers and posted on ICBHS Facebook page. There was a link provided to a survey that offered respondents to provide ideas about topics for an innovation project that meets the needs of the community.

Imperial County received 389 surveys (69 of which were from the age groups of 16 to 25) from stakeholders and community members identifying two main areas of consideration for the innovation project: 1) increase mental health access to unserved groups (140 of those surveyed): 2) increase the quality of mental health services (110 of those surveyed), (page 21).

The results identified that the essential target population that indicated the greatest need was for youth and young adults, between the ages of 13-25.

The focus on ***Wellness*** Services to increase mental health access to underserved groups and increase the quality of mental health services received the largest number of requests (159 surveys).

Ages, locations, gender, gender identity, primary language were all representative of the County (see pages 16-20).

A Mental Health Board hearing was conducted on June 1, 2021, and the County received comments related to increasing supervision time to ensure adequate supervision of the project, provide clear description of wellness activities, and include description of evaluation tools. These changes were incorporated into the final proposal.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on May 5, 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 June 2, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

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

Learning Objectives and Evaluation:

The County projects that it will serve 1000 youth and young adults based on its current caseload of 1,412 persons in this age group.

Quantitatively, the County hopes to learn if:

- Having peers as support persons will increase the number of youth and young adults who initiate participation in services or who will stay in services
- Holistic approaches to treatments facilitate an increase of participants and will that help them to remain engaged
- Having these two methods of engaging youth and young adults will reduce psychiatric emergencies/admissions

The County currently has the capacity, from its electronic health record system, to collect some of the demographic data required to document these qualitative questions and will rely on the evaluation contractor to develop those collection tools it currently does not have. Additionally, the County anticipates using "semi-structured" (page 12) interviews to collect this information.

Qualitatively, the County hopes to learn if:

- Having peer support helps to decrease stigma related to mental illness
- Having a holistic approach to recovery will motivate youth and adult youth to participate and stay engaged in mental health services
- Generally, and specifically for those who may be participating after a psychiatric emergency/crisis, does this innovation help reduce symptoms of mental illness and give the person an overall sense of wellbeing.

For data regarding these qualitative goals the County is proposing to use:

> . . .standardized measures including the 24-item Behavior and Symptom Identification Scale (Basis-24) and Youth Outcome Questionnaire Self Report (YOQ-SR). The Basis-24 is a behavioral health assessment tool for adults 18 and older designed to assess outcome of mental health or substance abuse treatment from the client's perspective. The YOQ-SR is a 64-item self-report that measures treatment progress for children and adolescents (ages 12-18) receiving mental health intervention (page 13)

Assuming positive outcomes and results, the County intends to sustain this project with CSS and PEI funds and possibly realignment funds.

The Budget

The County is requesting authorization to spend up to $3,455,605 in MHSA Innovation funding for this project over a period of three (3) years. $1,578,342 are funds subject to reversion on June 30, 2021.

Funding Source	FY 21/22	FY 22/23	FY 23/24		TOTAL
Innovation Funds	**$1,080,871.00**	**$1,167,187.00**	**$1,207,547.00**		**$ 3,455,605.00**
Medi-Cal FFP	$ -				$ -
1991 Realignment					$ -
Behavioral Health Subaccount					$ -
Any other funding					$ -
5 Year Budget	FY 21/22	FY 22/23	FY 23/24		Total
Personnel	$614,181.00	$638,721.00	$666,416.00		$ 1,919,318.00
Operating Costs	$238,876.00	$257,966.00	$270,631.00		$ 767,473.00
Non-recurring Costs	$52,314.00				$ 52,314.00
Evaluation / Consultant / Contract	$175,500.00	$270,500.00	$270,500.00		$ 716,500.00
Other Expenditures					$ -
Total	$ 1,080,871.00	$ 1,167,187.00	$ 1,207,547.00		**$ 3,455,605.00**

Personnel costs in the amount of $1,919,318, represent 54% of the total budget:

- Non direct administrative staff (1.0 FTE Program Supervisor and 1.0 FTE Office Assistant)
- Direct Service Staff: (2.0 FTE Mental Health Rehabilitation Technicians, 2.0 FTE Mental Health Workers, 2.0 FTE Peer Support Specialists/Community Services Workers
- Indirect Staff: (.05 FTE Director/Deputy Director, .05 FTE Administrative Secretary)

Operating costs in the amount of $767,473 represent 22% of the total budget

- Inclusive of program and administrative costs

Non-recurring costs in the amount of $52,314 represent 2% of the total budget

Consultant/Contract costs in the amount of $716,500 represent 21% of the total budget

- Inclusive of evaluation contractor and wellness vendors and contractors

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the County must receive and inform the Commission of approval from Imperial County's Board of Supervisors before any Innovation Funds can be spent.

AGENDA ITEM 8

Action

June 24, 2021Teleconference Commission Meeting

MHSSA Contract Approval

Summary: The Commission will consider authorizing $50 million in grants to support twelve additional Mental Health Student Services Act (MHSSA) programs consistent with language in the Governor's January budget proposal and the May Revision.

Background: Senate Bill 75, Statutes of 2019, established the MHSSA, which provides $40 million one-time and $10 million in ongoing MHSA state administrative funds to support mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education. The goals of the MHSSA are to increasing access to mental health services in locations that are easily accessible to students and their families. Grants provide support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, placement assistance and service planning for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ, and youth who have been expelled or suspended from school.

In Fall of 2019 the Commission held listening sessions in Sacramento, Richmond, Fresno and Los Angeles. Participants raised concerns regarding the challenges facing communities that do not currently have school-county partnerships for school mental health. The concern was that communities with existing partnerships may have an advantage in responding to a Request for Application (RFA). Participants also expressed concern that $50 million was not sufficient to respond to local needs and encouraged the Commission to explore options to make available additional resources.

In December 2019, the Commission released a Request for Applications (RFA) for MHSSA grants in two categories, Existing Partnerships, Category 1, and New or Emerging Partnerships, Category 2. In April of 2020, after a competitive grant process, the Commission awarded $45 million in funding for the following counties in MHSSA Category 1 (Existing Partnerships):

County:	**Grant Total:**
Humboldt	$2.5 million
Mendocino	$2.5 million
Placer	$4 million
San Luis Obispo	$4 million
Solano	$4 million
Tulare	$4 million
Fresno	$6 million
Kern	$6 million
Orange	$6 million
Ventura	$6 million
Totals:	**$45 million**

In July of 2020, the Commission awarded $30 million in funding for the following counties in the MHSSA Category 2 (New or Emerging Partnerships).

County:	**Grant Total:**
Calaveras	$2.5 million
Madera	$2.5 million
Tehama	$2.5 million
Trinity/Modoc	$2.5 million
Santa Barbara	$4 million
Yolo	$4 million
San Mateo	$6 million
Santa Clara	$6 million
Totals:	**$30 million**

The January 2021 Governor's budget proposal included an additional $25 to support six school-county partnerships who were not funded in the procurement and the May Budget Revision included $30 million to support six additional unfunded school-county partnerships and funding to conduct a statewide evaluation of program outcomes. The Commission's contract authorization for twelve additional partnerships totaling $50 million, made available in the Budget Act of 2021, will provide funds to the following programs, which had the next highest application scores in their respective categories:

County:	**Grant Total:**	**Category**	**Size**
Amador	$2.5 million	2	Small
Glenn	$2.5 million	1	Small
Imperial	$2.5 million	2	Small
Lake	$2.5 million	1	Small
Marin	$4 million	1	Medium
Monterey	$4 million	1	Medium
Santa Cruz	$4 million	2	Medium
Sonoma	$4 million	2	Medium
Contra Costa	$6 million	2	Large
Riverside	$6 million	2	Large
Sacramento	$6 million	1	Large
San Diego	$6 million	1	Large
Totals:	**$50 million**		

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants

Enclosures (2) Mental Health Student Services Act; (2) MHSSA Program Summaries

Handout: (1) PowerPoint presentation

MENTAL HEALTH STUDENT SERVICES ACT

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5952]

(Division 5 repealed and added by Stats. 1967, Ch. 1667.)

PART 4. THE CHILDREN'S MENTAL HEALTH SERVICES ACT [5850 - 5886]

(Part 4 repealed and added by Stats. 1992, Ch. 1229, Sec. 2.)

CHAPTER 3. Mental Health Student Services Act [5886- 5886.]

(Chapter 3 added by Stats. 2019, Ch. 51, Sec. 67.)

5886.

(a) The Mental Health Student Services Act is hereby established as a mental health partnership competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Mental Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application. The county, city, or multicounty department, or consortium, shall be the grantee and receive any grant funds awarded pursuant to this section even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children from their homes.

(viii) Involuntary mental health detentions.

(4) That the plan includes a description of the following:

(A) The need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of school age youth in participating educational entities when determining grant amounts.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(i) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(j) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022. The report shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the school age children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) A report to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(k) This section does not require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(l) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis in order to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(m) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(Added by Stats. 2019, Ch. 51, Sec. 67. (SB 75) Effective July 1, 2019.)

Mental Health Services
Oversight & Accountability Commission

MHSSA Background:

The Mental Health Services Oversight & Accountability Commission (MHSOAC) administers the Senate Bill 82 Investment in Mental Health Wellness Act which provides local assistance funds to expand mental health crisis services. The Commission recognizes that the effects of mental health crises are evident on school campuses and that reaching pupils in the school setting is practical for a first point of contact for mental, behavioral, and substance use disorder services for youth. Schools provide an opportunity for early identification and early intervention to address behavioral health issues that can undermine learning and health development.

Improved access to mental health services is foundational to supporting children and youth develop into healthy resilient adults. Comprehensive models and integrated services that are tailored to individual and family needs, have the best chance of improving health and academic outcomes. The Mental Health Services Act is intended to foster stronger school-community mental health partnerships that can leverage resources to help students succeed by authorizing counties and local educational agencies to enter into partnerships to create programs that include targeted interventions for pupils with identified social-emotional, behavioral, and academic needs. School-community mental health partnerships offer an opportunity to reach children and youth in an environment where they are comfortable and that is accessible.

The MHSOAC makes Triage funding available to counties through a competitive grant process to expand access to services for children and youth. In 2017, the MHSOAC released SB 82 funds, with 50 percent of those funds dedicated to children and youth aged 21 and under. Additionally, the MHSOAC set aside approximately $20 million for four School-County Collaboration Triage grants with the aim of 1) providing school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families/caregivers, and 2) supporting the development of partnerships between behavioral health departments and educational entities.

Under that funding program Humboldt County, Placer County, Tulare County Office of Education, and California Association of Health and Education Linked Professions Joint Powers Authority in San Bernardino was awarded $5.3 million over four years. The four School-County partnership programs are supporting strategies to 1) build and strengthen partnerships between education and community mental health, 2) support school-based and community-based strategies to improve access to care, and 3) enhance crisis services that are responsive to the needs of children and youth, all with particular recognition of the educational needs of children and youth.

In addition to the four School-County partnership grantees, the MHSOAC awarded Triage contracts to counties to operate school-based Triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

As a result of the high-level of response to the school-county collaboration RFA and the implementation of school-based programs through the Triage RFA, the Legislature passed and the Governor signed the 2019 Budget Bill, Senate Bill 75, which included the Mental Health Student Services Act (MHSSA) to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities.

Categories of Funding:

During planning sessions, stakeholders raised concerns that communities with existing partnerships may have an advantage in responding to a Request for Application (RFA) compared to those with no existing partnership. In response to those concerns, in November 2019 the Commission approved the outline of the RFA which would make available $75 million in funding from four fiscal years, setting aside $5 million for implementation and evaluation, with program funding available in two categories: 1) funding for counties with existing school mental health partnerships ($45 million) and 2) funding for counties developing new or emerging partnerships ($30 million).

20 counties applied for Category 1 funding, 10 of which were awarded grants in April 2020. 18 counties applied for Category 2 funding and 8 additional grants will be awarded at the Commission's August 2020 meeting.

Grant Awards Breakdown:

The table on the following page includes a breakdown of the 38 county partnerships that applied for the MHSSA grants, including the 18 which were awarded and the 20 which were not awarded:

Applicant County Name	Size	Category	Awarded (18)	Not Awarded (20)
Amador	Small	2		X
Calaveras	Small	2	X	
Contra Costa	Large	2		X
Fresno	Large	1	X	
Glenn	Small	1		X
Humboldt	Small	1	X	
Imperial	Small	2		X
Kern	Large	1	X	
Lake	Small	1		X
Los Angeles	Large	1		X
Madera	Small	2	X	
Marin	Medium	1		X
Mariposa	Small	1		X
Mendocino	Small	1	X	
Monterey	Medium	1		X
Nevada	Small	2		X
Orange	Large	1	X	
Placer	Medium	1	X	
Riverside	Large	2		X
Sacramento	Large	1		X
San Bernardino	Large	1		X
San Diego	Large	1		X
San Francisco	Large	1		X
San Luis Obispo	Medium	1	X	
San Mateo	Large	2	X	
Santa Barbara	Medium	2	X	
Santa Clara	Large	2	X	
Santa Cruz	Medium	2		X
Shasta	Small	2		X
Solano	Medium	1	X	
Sonoma	Medium	2		X
Sutter-Yuba	Small	2		X
Tehama	Small	2	X	
Trinity-Modoc	Small	2	X	
Tulare	Medium	1	X	
Tuolumne	Small	2		X
Ventura	Large	1	X	
Yolo	Medium	2	X	

Category 1 Awardees (10):

Humboldt	Total Funds Received: $2.5 million	Partnerships: • Humboldt County Department of Health and Human Services – Children's Mental Health • Humboldt County Office of Education • All 32 school districts in Humboldt County which include all public and charter schools in Humboldt County

Summary of Services:
The Humboldt Bridges to Success (HBTS) program was established in 2018 and funded with a MHSOAC grant. This program created school-based mental health crisis-triage teams for all five regions of Humboldt County, and created a sixth team that specializes in mental health service for the 0-5 age group, enabling each regional team to provide the services and supports which best meet their community's unique cultural and geographic differences. MHSSA funds will be used to hire additional direct service personnel, fund HBTS program evaluation, and help sustain the project for approximately two additional years. The HBTS program is currently staffed by 17 positions, all of which are direct care staff. Grant funds will be used to increase program staffing by six and increase the supervising mental health clinician and a peer position to full-time.

The primary goal of HBTS is to provide school-based mental health intervention and support to students, in crisis or at risk of crisis. The program increases access to mental health services by providing intervention and services in locations that are easily accessible to students and their families. These staff work alongside other school personnel to:

- Identify students in need of support
- Determine and provide an appropriate, limited duration intervention or interventions
- Determine if the intervention was successful
- If successful, slowly discontinue the intervention and continue to monitor the student, or
- If necessary, assist the student in accessing more intensive, longer term services and supports

Mendocino	Total Funds Received: $2.5 million	Partnerships: • Mendocino Health and Human Services Agency, Behavioral Health and Recovery Services • Mendocino County Office of Education • Special Education Local Plan Area • Seven school districts including Anderson Valley, Fort Bragg Unified, Laytonville, Manchester, Potter Valley Community, Ukiah Unified, and Willits Unified • Three charter schools including Eel River, River Oak and Willits Elementary

Summary of Services:
The Mendocino County Student Services partnership is led by Mendocino County Behavioral Health and includes the Mendocino County Office of Education, behavioral health service providers, and school districts. The partnership delivers an array of services to students and their families through therapists, counselors, and other case managers working on-site at schools and through services offered in the community by established behavioral health providers in Mendocino County, including the Mendocino County Youth Project, Redwood Community Services, Redwood Quality Management Company, and Tapestry Family Services. MHSSA funds will be used to better bolster and expand existing services to Mendocino County students and their families. This includes linking and strengthening existing mental health services to better meet student's mental health needs, and enhance awareness, prevention and early intervention.

Grant funds will be used to increase program staffing by six and will apply for a Healthy Minds Alliance AmeriCorps to increase capacity to address mental health needs in the community. Service providers support the goals, mission, and vision of the partnership through:

- Outreach and engagement to students and families
- Screening for mental health concerns and assessing student needs and strengths
- Brief treatment and intervention
- Coodinating services and resources outside the school and help students access community resources and mental health services
- Follow-up with students, families, and community providers
- Crisis intervention
- Providing support and collateral services to teachers in responding to students' mental health concerns
- Identifying needs of family members and providing referrals and linkages to services and community resources
- Providing group mental health services to students

Placer	Total Funds Received: $4 million	Partnerships: • Placer County Children's System of Care • Placer County Office of Education • Special Education Local Plan Area • Four school districts including Auburn Union, Placer Hills Union, Colfax Elementary, and Placer Union High School

Summary of Services:

For 31 years, Placer county has had a System of Care structure called the System Management Advocacy Resource Team (SMART), which is focused on the key outcomes for Placer County for children and families to be safe, healthy, at home, in school, and out of trouble. MHSSA funds will be used to broaden Placer County's existing System of Care partnership with school-based programs, increased staff, and expanded access on school campuses to a continuum of services and supports for children and their families, by creating and sustaining a Wellness Center at each of four school sites.

Each Wellness Center will not only be a program, but also a physical space on campus where staff will be co-located. It will be a mental health resource and provider site where students and their families can access prevention, early intervention, intensive, and crisis mental health services and referrals. It is also where school staff can access the program for training, consultation and increased mental health literacy.

Grant funds will be used to hire four Mental Health Specialists and three Family and Youth Community Liaisons to provide services at the Wellness Centers, which will also utilize existing school-based mental health staff, who will be reallocated and trained. In addition to the array of school based mental health services offered by the new Wellness Program, the Wellness staff will:

- Assist students and families with linkage to community-based referrals
- Help families initially access services and support the ongoing use of services
- Provide mental health education to school staff
- Partner with teachers to infuse social emtoional learning and mental health content into their curricula
- Engage parents and families to reduce complicating factors that impact mental wellbeing, such as food and housing insecurity, access to health care, and employment

Staff will also merge into the community for family and student support, including providing trainings for families in places where they live and work, and will blend into the school community providing presentations in classrooms and responding to mental health needs throughout the campus.

San Luis Obispo	Total Funds Received: $4 million	Partnerships: • County of San Luis Obispo Behavioral Health Department • San Luis Obispo County Office of Education • Six school districts including Lucia Mar, Paso Robles, San Luis Coastal, San Miguel, Shandon, and Templeton

Summary of Services:
The County of San Luis Obispo Middle School Comprehensive Partnership was established to build school and community cultures which promote social-emotional development, eliminate stigma, and provide access to care for students with mental health challenges. It established the Middle School Comprehensive Program to build collaborative teams at six of the counties middle schools. While 12 middle schools submitted proposals, funding limits dictated that only six schools could be supported.
Currently, MHSA funds support a lead behavioral health specialist, a youth development specialist, and a family advocate on each school's team, and each school provides its counselors, administrators, nurse, and faculty to form a multidisciplinary team to help identify and care for students at the earliest stage of risk.

MHSSA funds will be used to expand this partnership to provide the other six middle schools with the Program. The expanded partnership will build collaborative teams with the goal of increasing access to mental health services, reducing risk, and increasing protective factors.

Grant funds will be used to hire nine staff, including five Behavioral Health staff, and three Family Advocates, who will provide the following services:

- On-campus prevention, screening, early intervention, counseling, and referral
- On-campus youth development activities and engagement, including stigma reduction activities and education
- Mental health assessments and treatments
- Bilingual case management services to families

By expanding the Program to the six new middle school sites, the county will be able to make a significant countywide impact on increasing mental health outcomes, including access to care and protective factors for vulnerable populations, reduced stigma and negative outcomes stemming from social-emotional challenges and school failure.

Solano	Total Funds Received: $4 million	Partnerships: • Solano County Behavioral Health • Solano County Office of Education • Six school districts including Benicia, Dixon, Fairfield-Suisun, Travis, Vacaville, and Vallejo City

Summary of Services:

The Solano County Student Wellness Partnership between Solano County Behavioral Health Division and Local Education Agencies supports the social-emotional wellbeing, learning, and resilience of Solano County's children and youth by providing a full continuum of school-based mental health, and community resources to all K-12 students. This partnership has led to the ongoing development of a growing network of culturally responsive school Wellness Centers across the county in K-12 and adult education sites.

The Student Wellness Partnership project will further enhance the efforts made to address critical gaps in school-based programming by significantly increasing the capacity of educators and school staff to identify and respond to mental health needs, and increasing timely access to mental health services for students at risk of dropping out and/or high-risk youth. It will also significantly improve the crisis response provided to K-12 students in schools in several Solano County school districts.

MHSSA funds will be used to support four full-time and 13 part-time school-based clinical positions, to provide direct school-based mental health and crisis services. School districts will participate in either of two service tracks:

- Track 1: Training and Technical Assistance (six school districts)
  - Trainings will be offered to teachers, classified staff, parents, classes, and student/peers, according to the individual needs of each district
  - Trainings will primarily be offered on local school campuses
- Track 2: Direct Services and Crisis Response (three school districts)
  - Provision of screenings and/or assessments for students who need ongoing mental health services
  - Crisis response, including phone triage, in-person crisis evaluation, crisis intervention and planning
  - Enhanced support groups and wellness/resilience services provided by interns at Wellness Centers
  - Pilot implementation of peer model that leveraged parent liaisons to provide support for families impacted by a child/youth experiencing a crisis and/or being at risk of drop-out
  - Universal screening of incoming kindergartener's (Dixon only)

Tulare	Total Funds Received: $4 million	Partnerships: • Tulare County Mental Health • Tulare County Office of Education • 44 school districts • Valley Life Charter

Summary of Services:

The Tulare County Mental Health and Tulare County Office of Education partnership focuses on meeting the mental health needs of students throughout the community. This partnership is in the second year of implementing the School-County Collaboration Triage Grant, which has several key components, including the placement of Triage Social Workers in 48 schools across the county, providing mindfulness training to students, and providing numerous trainings related to supporting youth mental wellness and suicide prevention to schools, families, community members, and mental health professionals. MHSSA funds will be used to expand the current program and includes hiring additional Triage Social Workers to serve additional schools throughout Tulare County.

Grant funds will be used to hire ten staff, including six Triage Social Workers and two Mental Health Clinicians. The Triage Social Workers will become part of the school community and provide services on school campuses, as well as provide services and support to families in their homes and community settings, including:

- Identify families in need of services and supports, including assessment, parenting support, family intervention services, linkage, and referrals to community services
- Teach mindfulness to children and adolescents using the K-12 Mindful Schools Curriculum
- Implement Coping and Support Training to target middle and high school-aged youth to build self-esteem, monitor and set goals, decision making and personal control
- Collaborate with mental health prevention and early intervention programs that serve the region and provide targeted early intervention services

Grant funds will also be used to:

- Support the development of a collaborative system to provide training, support, and assistance to local pediatrician's offices to screen children using the Adverse Childhood Experiences screener
- Form a new partnership with Tulare County Probation and provide a free Triage Social Worker for two days a week to provide social work services to youth who are currently incarcerated or recently released
- Expand the Peer Support Specialists component
- Expand the Mental Wellness Training team

Fresno	Total Funds Received: $6 million	Partnerships: • Fresno County Department of Behavioral Health • Fresno County Superintendent of Schools • 32 school districts

Summary of Services:
In 2016, the Fresno County Department of Behavioral Health and the Fresno County Superintendent of Schools formed the All 4 Youth Partnership, whose mission is to create an integrated system of care that ensures all children in Fresno County have access to behavioral health services to support their social, emotional, and behavioral needs and to promote a positive healthy environment. All 4 Youth works to expand mental health treatment and prevention and early intervention services for youth at school, home, and community locations in Fresno County.

MHSSA funds will be used to expand prevention and early intervention services for youth aged 0-22 throughout Fresno County. The partnership will expand its current model of care to serve more youth with mental illness and their families through a strengths-based, person-centered approach that focuses on prevention and early intervention, and connects youth with needed therapeutic services through the existing All 4 Youth Hubs.

Grant funds will be used for the construction and facilities improvements to develop four new, school-adjacent Wellness Centers in areas of the county with high-need and where the All 4 Youth Partnership has been unable to acquire facility space. Grant funds will also be used to hire 12 staff (Family Partners) over four years. 21 staff will be utilized as "in kind."

Through the Wellness Centers the Partnership will:

- Provide accessible information and host trainings to increase student, family, school staff, and community knowledge about trauma and mental health
- Provide mental health prevention and intervention services in accessible locations including schools, the community and a home
- Promote mental health for all and reduce stigma around mental health to increase the likelihood of accessing services
- Provide strategies and training for comprehensive self-care for families, students, and school staff, and
- Collaborate with schools and districts to extend the implementation of their *Natural School Mental Health Curriculum: Guidance and Best Practices for States, Districts, and Schools* to families and communities

Kern	Total Funds Received: $6 million	Partnerships: • Kern County Behavioral Health & Recovery Services • Kern County Superintendent of Schools • Five school districts including Bakersfield City, Greenfield Union, Kern County Superintendent of Schools Alternative Education, Kern High, Panama Buena Vista Union

Summary of Services:
The Kern County Network for Children, established in 1992 by the Kern County Behavioral Health & Recovery Services and the Kern County Superintendent of Schools, developed the Kern Youth Resiliency Partnership (KYRP), to expand school community partnerships in Kern County. KYRP is designed to provide targeted campus-based mental health services that will build resiliency, improve school connectedness and attendance, and increase access to mental health services for the most at-risk youth in Kern County.

MHSSA funds will be utilized to implement a Multi-tiered System of Support mental health approach designed to increase access to mental health services by establishing new mentoring programs, offering school-based after-hours mental health services, and improving the cross-agency continuum of care:

- Tier 1 includes early intervention and monitoring
- Tier 2 includes Americorps Mentoring
- Tier 3 includes dedicated mental health team that will provide services to foster and homeless students

Grant funds will be used to hire qualified mental health teams and provide direct targeted services at five school districts in Kern County. Each mental health team includes a LCSW/LMFT, Case Manager, and Substance Abuse Counselor. 14 staff will be hired in year 1, increasing to 17 in year 4, and include the mental health teams as well as AmeriCorps Mentors. Mental health teams provide the following services:

- Screen foster and homeless youth for ACEs
- Pilot a universal screening tool for all students
- Pilot a screening tool to assess PreK-3rd grade
- Ensure that Check In/Check Out rapid response intervention to support academics, behavior and social and emotional health is implementing with fidelity
- Screen students using a Biopsychosocial Assessment in addition to the PHQ9, GAD 7 and Columbia Suicide Rating Scale
- Provide school-based therapeutic services for youth and families (during school and after-hours)
- Substance abuse counseling and case management services

Peer support is an integral component of the program and includes cross-age peer-to-peer mentoring as well as AmeriCorps Mentoring for foster and homeless youth.

Orange	Total Funds Received: $6 million	Partnerships: • Orange County Health Care Agency • Orange County Department of Education • 29 school districts • Oxford Preparatory Academy

Summary of Services:
Since 2010, there has been an existing partnership between the Orange County Department of Education (OCD), which serves as the County Office of Education, and the Orange County Health Care Agency (HCA) Behavioral Health Services (BHS). In addition, there is a service agreement with Santa Ana Unified School District. OCD provides Positive Behavioral Intervention and Supports and Violence Prevention Education Services as a broad range of personalized social development services that are culturally and linguistically appropriate. OCD also provides clinicians and case managers to schools in Santa Ana Unified School District to provide professional development for teachers on mental health issues, to provide school-based individual group and family therapy, and to facilitate student support groups. The HCA BHS administers a full continuum of mental health services including prevention and early intervention services, outpatient treatment, residential treatment, and crisis services.

MHSSA funds will be used to implement an educational-health partnership approach to improve collaboration between the educational and behavioral health systems to provide and coordinate mental health services and linkages, as well as train school staff on mental health topics.

Grant funds will be used to hire seven regional Mental Health Student Services Coordinators to provide and coordinate an array of prevention, education/training, early intervention, and intensive services to help fill existing gaps in connecting students and families to mental health services. The Coordinators will collaborate with school staff and families to facilitate coordination of care and linkages to this continuum of care. Coordinators will provide services, including, but not limited to:

- Provide ongoing coordination of partnerships between HCA BHS, districts, schools, and community providers
- Conduct needs assessments with districts in their region to customize needed services and trainings for students, parents, and school staff
- Develop communication pathways, monitor activities and needs and adjust activities based on evolving district needs surrounding mental health services and trainings
- Identify regional resources and serve as the “regional expert” of mental health services
- Coordinate and/or provide education and training for teachers, students, parents, and families on mental health issues
- Coordinate and support student wellness team members in a regional collaborative

Continued

Orange Continued

- Provide care coordination to facilitate access to mental health resources and trainings for parents and caregivers of at-risk students, including serving as a liaison with districts to educate parents and students at high risk about mental health resources and trainings, and coordinate partnerships with community agencies

- Facilitate targeted outreach and improved access to services for at-risk students
- Coordinate and provide targeted outreach and linkage to students identified as high risk
- Coordinate and provide intensified outreach and linkage to services for students who are identified as being in crisis
- Provide and coordinate professional development in districts for teachers on mental health topics
- Facilitate and coordinate trainer of trainer opportunities for district and school staff

Ventura	Total Funds Received: $6 million	Partnerships: • Ventura County Behavioral Health Department • Ventura County Office of Education • Five school districts including Fillmore, Moorpark, Oxnard, Santa Paula, and Ventura

Summary of Services:
The Ventura County Mental Health Services in Schools Partnership was established in 2012 between the Ventura County Behavioral Health Department and the Ventura County Office of Education. Its mission is to provide service strategies in schools that increase early identification of mental health needs, reduce access barriers, prevent mental health issues from becoming severe and disabling, and facilitate linkages to ongoing and sustained services. The partnership provides mental health and support services for Ventura County's students with special education needs, as well as for additional populations of youth at highest risk of mental health care needs, and has continued to expand services and incorporate a continuum of school-based mental health services by establishing projects in 15 of the county's 20 school districts.

Using MHSSA funds, the Ventura County Wellness Center Program is being established to augment the partnership's mission. The Wellness Centers will be designed to be a "safe haven" for students, including those with mental health needs, to access services in a recovery-focused environment. They will be located in eight high schools within five school districts. These high schools have the greatest need for services and have available space to dedicate to the program. The Wellness Centers will reduce access barriers (e.g., transportation, cost, and stigma) and improve mental health and educational outcomes. Services provided through the Wellness Centers will specifically address suicide prevention, drop-out prevention, placement assistance and service planning for students in need of ongoing services, and outreach to high-risk youth.

Grant funds will be used to hire staff and contractors including Wellness Coordinators, Wellness Clinicians and Wellness Peers. A Wellness Coordinator will oversee all activities within each Wellness Center, including:

- Provide mental health screenings and counseling
- Provide mental health education and training
- Coordinate early intervention services/short-term counseling
- Support crisis intervention as indicated
- Develop and implement the school-based communications program
- Provide ongoing supervision and program management of Wellness Peers
- Maintain service data to support program evaluation, and
- Arrange brief interventions for alcohol and drug offenses
- Refer students with more intensive mental health needs to the assigned clinician to provide linkages to care providers and a more complete evaluation and assessment

Category 2 Awardees (8):

Calaveras	Total Funds Received: $2.5 million	Partnerships: • Calaveras County Health and Human Services Agency/Behavioral Health Division • Calaveras County Office of Education • Four school districts including Bret Hart Union, Calaveras Unified, Mark Twain Union Elementary, and Vallecito Union • Mountain Oaks Charter

Summary of Services:

The vision of the County-Educational Entities partnership is for a continuum for student mental health services on elementary campuses that will have three tiers: (1) Proposed: Mental Health Wellness Centers at elementary schools and other programs in middle and high schools (2) Current: The Calaveras Care Team for families with complex issues that require a coordinated approach (3) Current: Crisis protocols and processes that keep students in trauma-informed care from the time they are identified on campus to the time they are hospitalized (or safety planned, or incarcerated). The Program Plan will add to, and complete, the components, which have already been put into place. The intent is to develop an infrastructure that allows the clinical service providers to be on elementary school campuses where they are needed, when they are needed for students, while offering staff support and parent education for all campuses.

Grant funds will be used to staff and operate Mental Health Wellness Centers on elementary school campuses, including hiring two Licensed Clinicians, three Mental Health Specialists, two Supervising Licensed Clinicians, and a Program Evaluator. Sierra Child and Family Services, a non-profit community-based agency, is selected as a partner in the program because they have experience operating school based mental health programs in El Dorado County Union High School District. There are already multiple services provided on the school campus, and the Wellness Center staff will be able to link students to those services as appropriate for the student. Specifics for the program include:

- Teams, assigned to a specific school site, that will consist of a supervising licensed clinician, a licensed clinician, and a family specialist
- All students are eligible to participate in the services offered by the Wellness Center, regardless of their financial/insurance status
- Students referred to the team (by staff, teachers, family/parents) will receive individual assessment and treatment as needed, when deemed appropriate by the Supervising Clinician
- Services to students may include crisis support, brief mental health assessments, outreach and engagement, linkage/navigation to community services, therapy (includes DBT), activities/skills training to emphasize self-care, and mental health awareness
- When not working directly with students, the teams/members will: provide mental health trainings for school staff; provide mental health classes to students, parents, and the community; work with student leadership and student mentors on mental health issues, supports, communication; make connections with other services providers/services
- When needed, a team/member will respond to behavioral/mental health crisis on campus

Madera	Total Funds Received: $2.5 million	Partnerships: • Madera County Behavioral Health Services • Madera County Office of Education • 10 school districts • Three charter schools including Sherman Thomas, Western Sierra, and Ezequiel Alvarado

Summary of Services:

The Madera County Youth Behavioral Health Collaborative provides increased access to mental health and behavioral health services in the school, home and community to students throughout Madera County who are identified as in need of mental health support and intervention. The goals of the partnership are to:

- Increase access to behavioral health services in locations that are easily accessible to students and their families
- Emphasize preventive and early intervention services that maximize the healthy development of children and minimize the long-term need for public resources
- Provide case management services to children and families with multiple needs
- Enhance crisis services that are responsive to the needs of children and youth
- Facilitate linkages and access to a continuum of ongoing and sustained services for students with identified social-emotional, behavioral and academic needs
- Identify gaps in services to targeted populations

The program will address two county-wide needs (1) navigation and case management services for students and families and (2) additional capacity to assist with new interventions before calling school resource officers or law enforcement to conduct an assessment for a 5150 hold. Grant funds will be used to contract with Camarena Health, the county's largest community health care provider, to hire three Behavioral Health Community Navigators (BHCN), two Licensed Clinical Social Workers (LCSW), and a Program Coordinator.

Each BHCN will be assigned to one of three regions within the county. They will ensure the students and their families are able to access the available resources and treatment options, coordinate care, and serve as a liaison to the school staff to ensure that students have the school-based support services they need to successfully return to and remain in class. The LCSWs will be deployed throughout the county to provide responsive additional capacity during an initial student crisis. Whenever possible, they will use interactive video and audio technology to provide support to school staff to de-escalate stressful situations and to develop preventative measures before a 5150 referral is made. Tele-mental health services will be a key service delivery strategy for this program, both to efficiently and effectively cover the geographic range of the mostly-rural county and to address potential social-distancing requirements brought about by COVID-19.

Tehama	Total Funds Received: $2.5 million	Partnerships: • Tehama County Health Services Agency - Behavioral Health Services • Tehama County Department of Education • Seven school districts including Corning Union High, Corning Elementary, Evergreen Union, Gerber Union Elementary, Lassen View Union Elementary, Red Bluff Elementary, and Red Bluff Joint Union High • Reeds Creek Elementary School

Summary of Services:

The Tehama County Student Services Collaborative (TCSSC) is a new partnership including the Tehama County Department of Education, Tehama County Health Services Agency, and multiple schools within Tehama County. The partnership will use a Strategic Prevention Process for implementation of the TCSSC project. Universal screening, assessment, implementation of Social Emotional skills, and professional development will occur throughout the four years of the grant cycle. All schools participating in the collaborative will establish or update their facilities to develop a Social Emotional Wellness Center on campus.

Grant funds will be used to hire staff, provide trainings, and make facilities improvements to Wellness Centers. Three Mental Health Wellness Clinicians will be hired to provide direct service to students, collaborate with teams, and provide professional development. A Mental Health and Wellness Clinician Coordinator will support data collection, analysis, and program implementation. The community partners Empower Tehama, Expect More Tehama, and First 5 Tehama will also be engaged with the plan.

The project implementation includes the following:

- All children ages 0-5 in Tehama County will have an ASQ or ASQ-SE and transition meeting prior to entering Kindergarten
- All grades K-3 and 4-6 will participate in Mind Up Curriculum to build Social Emotional wellness and self-regulatory skills
- Universal screening will occur at LEA's and mental health partners using the CANS
- Why Try curriculum will be implemented for grades 6-8
- Grades 9-12 will implement Botvin Life Skills
- All schools and partners will participate in professional development on Trauma Informed Practices and Adverse Childhood Experiences (ACEs)
- All schools will be trained in Applied Suicide Intervention Skills Training (ASIST)
- Use of peer partners in schools through programs such as Club Live, STATUS, and Leadership to build a student network whose emphasis is on mental health wellness

Trinity-Modoc	Total Funds Received: $2.5 million	Partnerships: • Trinity County Behavioral Health Services • Trinity County Office of Education (TCOE) • Modoc County Office of Education (MCOE) • 12 school districts • California Heritage Youth Build Academy (CHYBA)

Summary of Services:
This new partnership with Trinity County Behavioral Health, Trinity County Office of Education, CHYBA, all Trinity County school districts, and the Modoc County Office of Education will bring wellness liaisons to schools to assist students with their mental health conditions, and to train staff in early detection and intervention. By providing personnel and peer support, this partnership will create linkages through the wellness liaisons between students, the triage team, community partners, and mental health providers.

The partnership will contract with Pathways to Success and will be assisted by the Pathways to Success Implementation Team (Implementation Team), which will implement their directives and manage the program. In addition, each school district in Trinity County, Modoc County, and CHYBA will have representation on the team to provide region specific feedback and guidance.
The Implementation Team will be composed of 23 members including:

- 18 School Liaison/Counseling Technicians
- 3 School Social Workers/Clinicians
- 1 Program Director
- 1 Program Director Administrative Assistant

The Social Worker/Clinicians and School Liaison/Counseling Technicians will be based at the schools and will directly serve students in schools (and other settings when directly working with preschoolers and families).

Social Worker/Clinicians will primarily provide direct services to students requiring mental health interventions. School Liaison/Counseling Technicians will provide students, parents, and staff with information and referrals to support students' success and will assist students with academic, attendance, and/or behavioral issues including implementing student disciplinary services and assisting parents and students in locating services (e.g. counseling, resource and intervention referrals) to increase student success.

All services will be provided on school campuses to include, but not be limited to trauma “toxic stress” informed strategies, suicide prevention and crisis teams, drop-out prevention, placement assistance and service plans for students who need ongoing services.

Santa Barbara	Total Funds Received: $4 million	Partnership Entities: • Santa Barbara County Department of Behavioral Wellness • Santa Barbara County Education Office • 20 school districts

Summary of Services:
The collaborative partnership between the Santa Barbara County Office of Education and County of Santa Barbara Behavioral Health Services will ensure seamless linkages to prevention and intervention resources, including securing appropriate levels of behavioral health services for County youth and their families. The design of the program is heavily centered on providing students and their families with access to Navigators and program Clinicians to facilitated access to mental health services.

Grant funds will be used to hire personnel to support mental health prevention, early intervention and crisis response activities, including coverage during the summer months, by providing direct services, making direct referrals to services and coordinating mental health training, educational opportunities and presentations to all stakeholders. Personnel hired include a Project Manager, a Research Evaluator, two Clinicians, and six contracted Navigators.

Navigators and Clinicians will have direct contacts for "warm hand-offs" to Behavioral Wellness and community mental health providers. The Project Manager will work with mental health and healthcare providers to increase awareness of the Program and ensure direct lines of communication are established and proper procedures are in place to share necessary information for comprehensive case management provided by Navigators. Additionally, students, school staff and parents will be provided with opportunities to increase their knowledge of emerging mental health issues and how to intervene to mitigate possible escalation of symptoms.

The Navigators will be peer positions, and will provide the following services:

- Facilitate linkages to resources with warm hand-offs
- Case management for students needing long-term services
- Assist with community and on-campus mental health and wellness presentations

The Clinicians will provide services including:

- Crisis intervention support
- Coordinate integration of PBIS/MTSS with mental health services
- Supervise navigators with case management and assist with access to services
- Support student re-entry after crisis intervention

Yolo	Total Funds Received: $4 million	Partnership Entities: • Yolo County Health and Human Services Agency • Yolo County Office of Education • Five school districts including Esparto, Davis Joint, Washington, Winters, and Woodland

Summary of Services:
The Yolo County-School Partnership will provide school-based mental health prevention and intervention services and supports to students, and will use a team approach for an integrated, multi-tiered mental health service delivery model. The partnership includes every kindergarten through high school public school in Yolo County. Working alongside school personnel, project staff will increase access to the continuum of mental health services by providing prevention and intervention services in locations that are easily accessible to students and their families. The partnership will contract with community-based organizations (CBO) for culturally/linguistically matched direct service personnel and will provide evidence-based training for all direct care staff.

Grant funds will be used to employ a Project Manager, and an Administrative Analyst, and will fund regional contracts with CBOs. The CBOs will provide a continuum of preventive and interventive mental health services in each of Yolo County's five school districts and County Office of Education schools using the following staff:

- School Based Supervising Clinicians to supervise and support school-based team members
- School Based Clinicians to provide direct care, training, and local coordination
- Navigators/Outreach Workers to provide direct mental health supports and services, trainings, and coaching

Specifically, the team will:

- Improve school climate on individual school campuses
- Identify individual students in need of additional support
- Establish and provide appropriate, limited duration intervention(s) on the school campus or appropriate locations chosen by the youth and families
- Determine if the intervention(s) was successful
- Assist with navigation and transition to informal community/cultural services and supports when appropriate for individual students and/or family
- Assist the student and family in accessing more intensive, longer term services and supports

San Mateo	Total Funds Received: $6 million	Partnership Entities: • San Mateo County Behavioral Health and Recovery Services • San Mateo County Office of Education • 12 school districts

Summary of Services:
Formed in early 2020, San Mateo County's SYSTEM Support (Success for Youth and Schools through Trauma-Informed & Equitable Modules) is a new partnership between San Mateo County Health, Behavioral Health and Recovery Services (BHRS) and the San Mateo County Office of Education (SMCOE). This project will operate in two phases:

- Phase 1 for all 12 participating districts focuses on Tier 1 supports, i.e., training and coaching to implement one of three selected evidence-based Social Emotional Learning (SEL) curricula that will be delivered universally in schools to prevent, and provide for early identification of, mental health challenges.
- Phase 2 of the project is specifically designed to close identified equity gaps, and an investment will be made in hiring school- based Wellness Counselors for three districts that have over 20 schools, as well as one isolated continuation high school. These school sites will also receive training and support to implement additional promising SEL supports, and a universal screening tool to identify students at high risk of behavioral health challenges, including trauma. Upon early identification, students can be referred to Wellness Counselors for intervention. Students and families whose needs cannot be met at the school site level will be guided to CareSolace, an online mental health care matching resource, which will provide tailored assistance in locating follow-up care and treatment for more complex needs from a provider in the community.

Grant funds will be used to hire staff, including 6.75 Wellness Counselors, a Program Manager, and an Administrative Assistant. Wellness Counselors will:

- Work closely with teachers at school sites to identify students with various challenges (e.g., homelessness, experiences in the foster system, depression due to sexual identity issues, etc.)
- Perform crisis intervention and/or brief intervention therapy (individual and/or group) on a scheduled or drop-in basis
- Provide guidance regarding use of the universal screening tool
- Assist with the delivery of supplemental SEL curricula, including *Kit Grit* and *Wayfinder*

Grant funds will also be used to engage CareSolace, hire training vendors, and purchase SEL curricula.

Santa Clara	Total Funds Received: $6 million	Partnership Entities: • County of Santa Clara Behavioral Health Services • Santa Clara County Office of Education • 31 school districts

Summary of Services:
This collaborative partnership will utilize MHSSA funds to fill the gaps in existing prevention and early intervention mental health services in schools and provide strategies to support students during the Covid 19 crisis. Primary objectives are to create Wellness Centers on school sites, increase the number of mental health professionals at school sites, and provide relevant professional learning to educators.

The Wellness Centers will fill existing service gaps and will work collaboratively with existing services, utilizing the three Tiers of support:

- *Tier 1* activities are prevention based and focus on all students, including homeless and foster youth, youth who identify as LGBTQ, and underserved youth. Included are Social Emotional Learning activities and Restorative Justice practices, age appropriate resources and information about mental health issues, parenting classes and support groups, and referrals for needed services.
- *Tier 2* activities are early intervention and focus on students struggling with specific behavioral, emotional, or social functioning needs and will include groups or one on one check-ins.
- *Tier 3* activities are intervention for youth with the highest needs, and include short-term individual therapy, crisis assessment and triage and re-entry to school following suspension or expulsion.

Grant funds will be used to facilitate linkages and access to sustained services through the personnel hired. The personnel include eight Wellness Center Coordinators, four Wellness Center Liaisons, six Counseling Associates, eight Trainees/Interns, a MHSSA Coordinator, and a Data Technician.

Wellness Center Coordinators are responsible for running the Wellness Center including program implementation, day-today operations, coordinating direct services, and partnering to provide school-wide prevention and early intervention efforts.

Counseling Associates will provide individual, group, or family counseling in the school setting, perform assessments and create treatment plans, provide social-emotional classroom lessons, and accurately assess and provide crisis intervention.

MISCELLANEOUS ENCLOSURES

June 24, 2021 Commission Meeting

Enclosures (10):

(1) Staff Analysis: Sonoma County Instructions Not Included Innovation Project
(2) Innovation Plan: Sonoma County Instructions Not Included Innovation Project
(3) Staff Analysis: Sonoma County Collaborative Care Enhanced Recovery Project
(4) Innovation Plan: Sonoma County Collaborative Care Enhanced Recovery Project
(5) May, 2021 Motions Summary
(6) Evaluation Dashboard
(7) Innovation Dashboard
(8) Department of Health Care Services Revenue and Expenditure Reports Status Update
(9) Supported and Sponsored Legislation
(10) Calendar of Tentative Commission Meeting Agenda Items

Handouts: None

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – SONOMA

Innovation (INN) Project Name:	**Instructions Not Included**
Total INN Funding Requested:	**$689,860**
Duration of Innovation Project:	**3 Years**
MHSOAC consideration of the INN Project:	**April 22, 2021**

Review History:

Approved by the County Board of Supervisors:	Feb 23, 2021
Mental Health Board Hearing:	Dec 15, 2020
Public Comment Period:	Nov 13, 2020 – Dec 14, 2020
County *submitted* INN Project:	March 4, 2021
Date Project Shared with Stakeholders:	April 14, 2020; Nov 18, 2020; and Feb 10, 2021

Project Introduction:

Sonoma County is requesting $689,860 in Innovation spending authority to increase access to mental health services through in-home based services and target the needs of new fathers and engage them in the care of their child and partner by screening new fathers, identifying as male, for Male Postpartum Depression (PPD) using the Edinburgh Postnatal Depression Scale (EPDS with modified scoring for males) and Adverse Childhood Experiences (ACEs) questionnaire.

What is the Problem:

Sonoma County wants to address the lack of services that specifically include in-home screenings for early identification of PPD in new fathers and engage them in the care of their new child with their partner, beginning at birth. Sonoma County also identified the need to screen fathers for Adverse Childhood Experiences (ACEs), which impacts parents' overall resiliency and can help identify the potential for child maltreatment and neglect for those that yield high scores.

Sonoma County's *Instructions Not Included Proposal* was initiated by the community to provide in-home support to new fathers through screenings for male PPD and ACEs to address depression, suicidal ideation, and trauma, all of which may significantly interfere

with the care of the child. More specifically, the population to be served was questioned about parental preparation as well as a father who lost his wife to suicide due to PMD. The groups who participated all agreed that parental preparation and support was lacking and/or absent. There is also a growing body of research on father's with PPD and high ACEs' scores negatively impacting child and family functioning. ***There are currently no in-home services available in Sonoma County that provide first time fathers with screenings for male postpartum depression and ACEs.***

How this Innovation project addresses this problem:

Sonoma County's research of in-home child services yielded positive outcomes for child health, safety, and well-being. *Instructions Not Included* is tailored to address the needs of new fathers, spouses/partners and their children including:

- Providing home-based support for all parents
- Screening for Male Postpartum Depression and ACEs
- Providing community referrals
- Increasing awareness and prevention services for those at risk of suicide due to male Postpartum Depression

Sonoma County will focus their efforts on addressing the needs of new fathers suffering from PPD and elevated ACE scores by making referrals to key community resources.

The screenings will address three priority community challenges:

1) Familial and Intergenerational Adverse Childhood Experiences (ACES).
2) Parental depression and suicide risk; and
3) High prevalence of Substantiated Child Abuse Cases and fiscal burden to Sonoma County.

All in-home visits will include the father and female partner with one private session offered only to the father. The County will adhere to fluctuating state requirements due to the COVID 19 pandemic. As a result, in-home visits may require alternative meeting accommodations which may include virtual sessions, outdoor meetings, or scheduling sessions at Early Learning Institute's (ELI) on-site children's center. All visit parameters were based on developmental tasks of infants and parents (available in detail in the proposal). In-home services are offered to both parents to build trust and assist with stigma reduction.

The sessions include:

- VISIT 1: 4-6 weeks after birth; sooner if requested
- VISIT 2: 3-4 months after birth; (administer new PPD screening to father)
- VISIT 3: 9 months after birth; (administer ACES screening to father and mother)
- VISIT 4: 12 months after birth
- Father Only Visit – 6 months after birth or earlier if requested by father

The Community Program Planning Process

Local Level

The Community Program Planning Process (CPPP) for this project resulted in the following community requests: 1) To provide home-based support for ALL first-time parents; 2) Growing body of research on male Postpartum Depression and the subsequent need to address this problem; and 3) One request from a father who lost his wife to suicide due to Postnatal Depression.

The Early Learning Institute (ELI) held focus groups in August-September 2019 to consult with the first-time parent population. The results indicated that fathers received less preparation and early support than mothers. In August-September 2019, five CPP meetings were held in different areas of the community. Sonoma County received 16 RFA's with a variety of mental health topics and this project was selected. Sonoma County is working on this project with the Early Learning Institute.

The proposed Innovation plan was posted for their local 30-day public comment on November 13, 2020 through December 14, 2020. No public comments were received. The proposal was approved by the County Board of Supervisors on February 23, 2021.

Commission Level

Commission staff originally shared this project with stakeholders on April 14, 2020 and after Commission staff provided additional TA was then shared again on November 18, 2020. The final version of this project was then shared with stakeholders on February 10, 2021.

No Comments were received in response to Commission sharing the plan with stakeholder contractors and the Commission's listserv on April 14, 2020, November 18, 2020, and February 10, 2021.

Learning Objectives and Evaluation:

Sonoma County will work with ELI to focus on providing identified in-home screenings for PPD, ACEs, and suicidal ideation for first time fathers, identifying as male, and their female partners.

The County identified six primary learning questions:

1) What percentage of new fathers are engaged in the INI home visiting program and complete both the PPD and ACEs screenings offered?
2) Identify the rate of paternal PPD in Sonoma County.
3) Identify availability of appropriate paternal PPD support, education, and counseling services in Sonoma County.

4) Identify the rate of high ACE scores in new fathers in Sonoma County.
5) Identify availability of appropriate ACE support, education, and counseling resources in Sonoma County.
6) Identify the co-occurrence of paternal PPD and high ACE scores.

The County states that all learning goals are related to offering screenings for PPD and ACEs to first-time fathers and anticipates serving 450 fathers, annually. The measures for screening include: The Edinburgh Postnatal Depression Scale (EPDS with modified scoring for males) and ACEs screening for fathers. Additional measures may be introduced as needed, such as the Nurturing Skills Competency Scale (NSCS) and/or additional administration of PPD screenings, on an as needed basis.

Data collection strategy for learning goals include:

1) Track home visits to accurately contract or expand the program.
2) Collect data on fathers who completed both screenings and number of referrals made to community providers, to support future services.
3) Improve understanding and prevalence of PPD and high ACEs scores to better provide in-home services for first-time fathers.

Sonoma County may wish to expand upon how the selected measurements support the learning goals.

Sonoma County may also wish to expand on how the number of self-reported, referral-based community connections will yield data to support learning for a reduction in substantiated child abuse cases and reduce the economic impact on Sonoma County. The measures currently identified in this proposal to assess PMD, depression, and trauma have been utilized to determine scores that identify the need for treatment, however, the County states they are making referrals for treatment but not completing post-treatment assessments to ensure treatment was effective, which may help to reduce the number of child abuse cases and substantial economic burden. The County plans to gather data on number of referrals provided to participants and depends on the clients self-report that contact has been made. However, the participant does not appear to report if they participated in a course of treatment, what type, and if they indicated that treatment was beneficial in treating PMD/elevated trauma scores.

The Budget *(see pages 27-31 for detailed project budget)*

The County is seeking authorization to use up to $689,860 in innovation funding over a period of three years. Sonoma County has $822,000 in Innovation Funds that are subject to reversion on June 30, 2021 and would like to use some of those in this project and three others. (Sonoma County has submitted a total of four innovation projects for approval that total $2,819,588).

The Early Learning Institute has secured additional funding for *Instructions Not Included* from the Chiat Foundation in an additional $100,000 per year, for three years, and from the Morton and Basset Foundation for $35,000 per year for 3 years.

Sonoma County also has a yearly reserve of $38,462 for unanticipated costs, totaling $115,386.

Budget Table

Funding Source	Year-1	Year-2	Year-3	TOTAL
Innovation Funds	**$217,382**	**$214,639**	**$215,839**	**$ 647,860.00**
Evaluation	**$13,000**	**$13,000**	**$13,000**	**$ 42,000.00**
Total Innovation Funding	**-**	**-**	**-**	**$ 689,860.00**
Behavioral Health Subaccount	-	-	-	$ -
Any other funding	$135,000	$135,000	$135,000	$ 405,000.00

3 Year Budget	Year-1	Year-2	Year-3	Total
Personnel	$198,224	$198,224	$198,224	$594,672.00
Direct Costs	$75,893	$75,893	$75,893	$2**30**,679.00
Indirect Costs	$48,060	$48,060	$48,060	$144,180.00
Non-recurring Costs	$2,743	0	$1,200	$ 3,943.00
Other Expenditures	$40,462	$40,462	$40,462	$ 121,386.00
				$ -
Total	$365,382	$362,639	$363,839	$ 1,091,860.00

- Personnel costs total $594,672 (54% of total funding) and includes:
  - 3.0 FTE In-Home Visitors'
  - .5 FTE Data Entry Specialist
  - .5 FTE Program Manager

- Direct Operating Costs –
  - Personnel (Taxes, Insurance, Healthcare, Vacation, and Sick Leave) total $130,827 (12% of total funding)
- Direct Costs – Operational
  - (Incentives for Books, Child Safety Items, Growth Charts, Puppets. Mileage) total $ 57,852 (5% of total funding)

- Indirect Operating Costs
  - Office Space, Computers, Communication, Internet total $144,180 (13% of total funding)
  - Evidenced Based Tools Training $2443 (less than 1% total funding)
  - Tablets for home visits $1500 (less than 1% total funding)
  - Evaluation total $42,000 (4% of funding total)

  - Stipends total $6,000 (.05%)

- Unanticipated costs $115,386 (9.5% of total funding)

Recommendations:

As a result of the COVID-19 pandemic, numerous challenges emerged for County's to provide services which temporarily impeded the ability to offer and provide care for consumers. New technological methods were implemented for continuation of care including but not limited to the use of tablets, outdoor sessions, and virtual-type sessions. These create new considerations to ensure that consumers are protected by HIPAA regulations with the implementation of multi-modal media utilization. County may wish to address HIPAA considerations in the use of tablets, outdoor sessions, visual media sessions, etc.

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

Instructions Not Included:

Home Visiting for new Fathers and Partners

Sonoma County Innovation **2021-2024** Plan Proposal

Table of Contents

Instructions Not Included – Home Visiting for New Fathers

GENERAL REQUIREMENT AND PRIMARY PURPOSE

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
	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

PRIMARY PROBLEM

The primary problem this project wants to solve is the lack of screening and early identification of perinatal mood disorders in new fathers and a resulting lack of understanding of the magnitude of the problem in Sonoma County. By not having the data, there continues to be a lack of prevention and early intervention services in Sonoma County that target the needs of new fathers and engage them in the care of their child and partner from the very beginning.

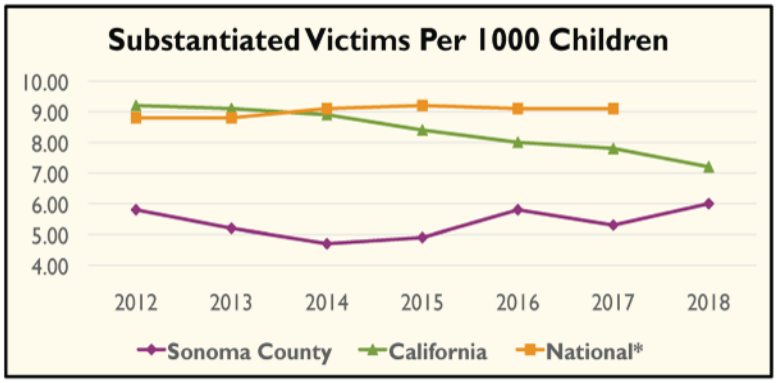
Currently in Sonoma County there are no services that specifically include screening for male postpartum depression (PPD) nor targets the emotional experience of a new father. Fathers are also not routinely screened for Adverse Childhood Experiences (ACEs), even though we know that this score can impact a parent's overall resiliency. [1] Both of these conditions – PPD and a high ACE score – are known to contribute to the potential for child maltreatment and/or neglect. By screening for both conditions, we can learn more about the prevalence of their co-occurrence in Sonoma County.

Instructions Not Included (INI) specifically offers screening for male PPD and provides ACEs screening for fathers as a way to support three priority community challenges:
1). Reduction of familial and intergenerational Adverse Childhood Experiences (ACEs);
2). Reduction in parental depression and risk of suicide; and
3). Reduction of Substantiated Child Abuse Cases.

Research shows that undetected and untreated parental depression places millions of children in the United States at risk each day. Parental depression can be especially damaging for the growth and healthy development of very young children, who depend heavily on their parents for nurture and care. In two large population-based cohorts, depressive symptoms in fathers during childhood were associated with adolescent depression aged 13-14. This association was independent of, and as strong as, maternal depressive symptoms. It was not affected by confounding factors. [2]

Additionally, we know that childhood experiences, both positive and negative, have a tremendous impact on resilience, future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important mental health and public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs). A 2014 study from the San Francisco-based Center for Youth Wellness shows that 20 percent of adults in Sonoma County experienced at least four ACEs. People who experience four ACEs, research shows, are 12 times more likely to attempt suicide, 10 times more likely to use intravenous drugs, seven times more likely to suffer from alcoholism, five times more likely to suffer from depression and twice as likely to experience heart disease, stroke or cancer.

Data from the UC-Berkeley California Child Welfare Indicators Project shows the California state rates of substantiated victims of child abuse is declining, however Sonoma County's rates are increasing. Research indicates an inter-generational transfer of trauma from those with high ACE scores to their children unless an intervention is conducted. The simple act of providing ACEs screening to parents and then discussing findings has shown to be an effective first step in breaking this cycle.



*National data unavailable for 2018

Sonoma County has prioritized gathering data on these mental health challenges as it begins to address multiple underserved and unserved populations with the promise of having a far-reaching impact on the overall wellness for families in the long term. This application addresses screenings for the following unserved and underserved populations: All New Fathers including Latinx new fathers. Sonoma County has

community-wide support for “upstream” programs that make an investment in the wellbeing of community members prior to psycho-social/socio-economic factors become disabling.

The development of this program originally grew from the intersection of three things: 1) multiple requests from the community to provide home-based support for ALL first time parents and 2) growing body of research on male PPD and impact of Father’s ACE score on child/family functioning; 3) A specific request from a 1st time father who lost his wife to suicide due to PMD. He felt that he did not have the knowledge, support or resources he needed that could have used to help himself or his family.

Based on this, the population to be served was also consulted for this program. In three separate focus groups held by the Early Learning Institute in August and September of 2019, mothers and fathers of children less than a year old were queried about the supports they received, both before and after the birth of their first child. Each group independently identified that the Father received less preparation and early support and that the mother was the primary focus of support and monitoring after the birth. Interestingly, when the focus groups were split into separate Father/Mother groups, most of the fathers were far more forthcoming about how hard the first 6 months of the child’s life was for them. One father said, “I wish I had known more about all the postpartum feelings that dad’s get. I thought I was supposed to feel jealous of the baby. Instead, I felt terrified and weepy – I would stay at work later and later trying to get grounded and feel like I had control of something.” Another father spoke of his need to “hit” stuff. He said he spent hours at the gym because he was afraid hurting his wife or baby. Of the 30 Father’s interviewed, only two had initiated couples-counseling and one had starting working individually with a therapist. Four fathers were currently separated from their partners. When asked to identify, on a scale of 1 –to-10 with 10 being high, what they had heard, read or knew about Paternal Postpartum Depression, the average score was “3”, with a high of “5” and a low of “0”. More than 50% of fathers in our focus group said they would like to, or be willing to, participate in a “first time parent” home visiting program with their partners. 24% indicated they would be willing to participate in a home visiting program without their partners.

One final point: currently in Sonoma County a child abuse report is made every hour and a half. While not all of those are substantiated, in 2018, total economic burden of child maltreatment in Sonoma County was $270 thousand PER case. If you take that number and multiply it by the number of substantiated child abuse cases (565) that translates into a lifetime burden of $158 million to the county incurred during 2018. Reducing this burden would allow for a community reinvestment of these funds into other mental health support services.

PROPOSED PROJECT (Research Citations in Appendix A)

Who We Are:

The Early Learning Institute (ELI) is a 501c3 nonprofit, incorporated in November of 1998. We are proud to be celebrating nearly 21 years of service to Sonoma County. When we opened our doors in 2009, early brain development was just beginning to impact the way we cared for infants and toddlers and their families. We now know that providing developmental supports as early as possible make a critical difference. Instructions Not Included aligns perfectly with ELI's mission and increased emphasis on early child-find activities and prevention by providing direct support to parents, especially fathers. We serve nearly 1,500 children per year across all our programs -- about 500 children at any one time in our weekly home visiting programs. We are a vendored program with the Department of Developmental Services as well as a contractor of the Department of Education. We serve all the SELPA children (through the County Office of Education) who are eligible for their early intervention home visiting services.

Seven years ago, First 5 Sonoma Conducted a survey among children serving nonprofits to see who they interacted with the most, on behalf of their clients. ELI's WMG program, the umbrella program for INI, was the most cited program, landing solidly in the middle of the referral bull's eye. We are the organization that helps parents navigate very complicated systems with warm hand-offs to community partners. We plan to continue this with INI. ELI has partnerships/MOUs with many other organizations, such as Public Health, Child Welfare, Child Parent Institute, Petaluma People Services, 4Cs, etc. as well as members of the medical community. These partnerships provide a two-way system of referral -- both into our programs and out to expedited entry into other services, should that be necessary. Like most nonprofits, ELI's Board of Directors provides oversight to the Agency as a whole and guides fulfillment of the Mission.

The programmatic operations follow a traditional model of Executive Director oversight with a Program Manager providing support and supervision to the field staff. The Executive Director (Michele Rogers) plays both an administrative function (fiscal oversight) as well as a hands-on function to INI. Michele Rogers is a certified lactation specialist and holds a PhD is Psychology. She will provide consultation and reflective supervision to the INI staff as needed. (All ELI staff are required to participate in reflective supervision.) General oversight and supervision of INI staff will be provided by Tina Moss, the WMG Program Manager. Tina is an Early Intervention Specialist and has been with ELI for 20 years. She provides clinical support and expertise on the intake team, with a particular expertise in newborn development. Her role is mostly supervisory at this point but she will take on particularly complex cases as needed. ELI's policy and philosophy is to serve all parents regardless of gender identity. So, while INI focuses on "fathers" – classically thought of as the male parent-- this program will be open to all new parents who seek out the service. Evaluation elements will only include parents who self-identify as male.

The Problem and the Project:
In Sonoma County, there are several home visiting programs (administered by community partners, not ELI) for new moms that include early screening and identification of maternal postpartum depression (PPD) or perinatal mood disorder (PMD). However, currently in Sonoma County there are no services that specifically include screening for male postpartum depression (PPD) nor targets the emotional experience of a new father. Fathers are also not routinely screened for Adverse Childhood Experiences (ACEs), even though we know that this score can impact a parent's overall resiliency. [1] Both of these conditions – PPD and a high ACE score – are known to contribute to the potential for child maltreatment and/or neglect.[1] The primary problem this project wants to solve is the lack of screening and early identification of perinatal mood disorders in new fathers and a resulting lack of understanding of the magnitude of the problem in Sonoma County. By not having the data, there continues to be a lack of prevention and early intervention services in Sonoma County that target the needs of new fathers and engage them in the care of their child and partner from the very beginning.

ELI's Instructions Not Included, (INI) will be the first program to target new fathers in a mental health focused home visiting intervention. ELI's evidence-based home visiting program will incorporate the strength of three main curricula: Promoting First Relationships, Partners for a Healthy Baby and Nurturing Fathers. Descriptions of all three can be found in Appendix B. INI is unique in that it will include the use of the Edinburgh Postnatal Depression Scale (EPDS with modified scoring for males) screening and ACE screening for dads. This project will consciously utilize the lessons of father recruitment and retention from the National Father's Initiative (NFI). NFI is a non-profit, non-partisan, non-sectarian organization that aims to improve the well-being of children through the promotion of responsible fatherhood. Headquartered in Germantown, Maryland, United States, its mission is to improve the well-being of children by increasing the proportion of children with involved, responsible, and committed fathers. ELI has utilized the trainings available through NFI to train staff and learn from other programs serving dads. NFI is NOT directly providing services to parents in Sonoma County. Mothers/Partners of the fathers, while not our specific target population are included in the screenings as part of a known best practice approach. Screening both caregivers lowers stigma and normalizes the need for screening. It is also a reasonable, responsible addition to this program as INI home visitors will have access to mothers who may not get screened otherwise. As a community, Sonoma County is engaged in an intent to reduce ACES through generational transmission as well as have multiple ways to identify and support caregivers who may have undiagnosed PMD.

Referrals to INI will be taken from Community Partners, Medical Professionals, and self-enrollment. Outreach will be done at birthing classes, Obstetricians, MH partners and other places likely to be seen by new parents.

The structure of INI will be to conduct 5 home visits with fathers with 4 open to both parents, strategically placed to coincide with known vulnerable periods during an infant's first year of life:

- VISIT 1: 4-6 weeks after birth; sooner if requested. (Surveillance for PPD happens at this visit.)
- VISIT 2: 3-4 months after birth; [administer PPD screening using the *Edinburgh Postnatal Depression Screen* (EPDS), with modified scoring for males.[21,22]]
- VISIT 3: 9 months after birth; (administer ACEs screening to father and mother.)
- VISIT 4: 12 months after birth
- **Father Only Visit** – 6 months after birth or earlier if requested by father.

Visits schedule will be somewhat flexible to meet the needs of fathers and families enrolled.

Visits were chosen based on the developmental tasks of infants and parents as follows: At 4-6 weeks of age, a baby begins to "wake up" and engage more with parents. This is a critical period of setting up attachment security for the baby, who relies on his/her parents to meet all needs. Research has shown over and over again that all learning for babies happens within the context of a relationship. This is a window of opportunity to establish a secure relationship for both the infant and the parents. Parents have settled somewhat into the demands of parenting and typically are beginning to read the baby's cues fairly well. Home visits delivered at this vulnerable point in time can scaffold cue reading, support fathers in their engagement and bonding with their infant and begin to establish trust between the father and the home visitor. Surveillance for PPD will be conducted and formal screening as needed for either parent.

At 3-4 months of age, infants are beginning to move (roll over, sit up, etc), are awake for longer periods of time and have distinct likes and dislikes. Brain growth is rapid at this age and is enhanced by appropriately stimulating activities, consistent care and nurturing. Fathers who may have been more tentative about caring for their newborns are now seen to be more firmly engaged in daily activities like bathing, feeding, diapering and playing. Research shows that this is a vulnerable time for fathers to develop PPD, which is why the screening is placed here. Fathers suffering from PPD can be guided to support services as early as possible and any intervention or redirection needed can be supplied. Home visitors can supply anticipatory guidance to fathers around child development, appropriate discipline, home safety concerns and other typical parental concerns.

At 9 months old, babies have often gained some kind of mobility – rolling, crawling, pulling up, and perhaps even starting to walk. This is a period of rapid growth and development as language begins to emerge, sleep patterns change and routines are disrupted. Separation anxiety also emerges, which can add stress to caregivers. Appropriate activities (screens? No screens?) and discipline strategies (too young for

time out?) are top of the mind for parents. Home visitors will use the ACE screening as a way to engage in a reflective discussion of the father's childhood experiences and how these may impact their choices around their parenting style. It is important to screen both parents at this visit, both to normalize the experience (not single out fathers) and to also create a reflective space for parents to compare notes and anticipate potential conflict of ideas and parenting styles. The home visitor can help fathers navigate this time by providing solid developmental education, which has been shown to reduce inappropriate expectations of many fathers, which in turn has been shown to reduce harsh disciplinary techniques.

At 12 months, babies are working on multiple emerging skills and are often described as "getting into everything." Fathers will be given additional child development resources and encouraged to seek out community supports and resources, both for the child and for themselves. As the last visit, the home visitor will be facilitating reflection of the first year, gentle reminders of the impact of a high ACE score if appropriate and ongoing surveillance for PPD.

The private visit offered to fathers is placed on the schedule at 6 months as this is an appropriate time to check in between the second and third visits. It provides the opportunity to also do surveillance on any previously identified PPD symptoms, follow up with community referrals. This visit will primarily be guided by the fathers concerns and questions and needs for support, if any.

Each visit has its own focus but will be largely driven by the needs and questions of the parents, with an emphasis on including the new father. In other words, there is nothing that precludes administering additional PMD or PPD screenings, if warranted. Home Visitors will be well trained to be alert to subtle and not so subtle signs of PMD and PPD and will respond accordingly.

ACEs screenings for adults are typically only done once unless there is cause for suspicion of withheld information (mostly due to trust issues.) The reason for this is that an adult's ACE score would not change over time – the score is for things that happen in childhood. As you can see from the schedule listed above, the ACEs screening is targeted for the 3 visit, at about 9 months after birth, so that trust is established. This is also a known time where discipline questions begin to emerge, as the baby is much more active and parenting becomes differently challenging. Research has shown that this is an effective time to build ACE awareness and link parent education to caregiver prior experiences. Intentional, frank discussion of the detriments of corporal punishment is most effective in this window of learning.

All screening tools will be discussed with the parents, so that they understand the purpose and intention to obtain consent. The Father Only visit (#5 above) is offered to allow full discussion of feelings, questions or other needs privately, based on the feedback of our father focus groups.

INI home visitors will administer the screenings, at the appropriate visits. These are

screenings, thus are not diagnostic tools. They do not need advanced training or credentials to administer. INI home visitors are required to have at least an Associates Degree (majority of staff currently hold a Bachelor's degree) and at least 5 years of experience working with parents. Our team has a variety of backgrounds in psychology, early childhood education, social work, teaching, etc. All home visitors are trained to do both in-person and virtual* home visits and have received training in all the chosen curriculums. There are bilingual, bicultural home visitors on the team and the INI home visitors have access to interpreters for languages beyond English and Spanish, as needed. All INI home visitors have all been trained, or will be trained by accessing available trainings from qualified partners, such as Sonoma County Public Health Nurses or through other relevant paid trainings. Michele Rogers, Executive Director, is a certified Master ACE's Trainer and is part of the Sonoma County ACEs training team. She will conduct internal trainings for the INI team in this area. Please see Appendix D for ELI's comprehensive employee training program. INI will be part of ELI's Watch Me Grow portfolio of programs. Staff hired into this department are all paid professional staff. Many have the lived-experience of being parents and/or having personal PPD issues but it is not a requirement to be a "peer" for this program.

If a new father is found to have a PPD/ACES score that warrants additional support, the home visitor will discuss community-based services, make a referral and support the connection to that referral. The home visitor will follow-up either with a phone call or at the next visit to determine if the new father was able to connect with those support services. All home visits will be documented into an electronic record for case management, the program evaluation process and to measure outcomes. Families are enrolled in the program over the course of their child's first year of life. As babies turn a year old, the family can choose to enroll in ELI's broader Watch Me Grow program and received bi-annual child development and social-emotional screenings and family check in. This gives the INI Home Visitor an opportunity to support referrals made during the last visit. However, this is a volunteer participation program. If a parent chooses to not seek resources offered, we cannot make them. There is no penalty for not following through, all home visits will still be delivered. All ELI employees are mandated reporters and receive annual training about child abuse observation and reporting. If they feel there is something to report, a protocol and MOU is in place with our Child Welfare partners.

<u>*COVID-19 precautions and adaptations</u>
Services for young children quickly and successfully adapted to the service changes demanded by the COVID-19 pandemic. All visits are now available to parents in a variety of ways: conducted outside, with masks on; conducted inside at ELI's children center, utilizing recommended enhanced cleaning protocols; or virtually, over a secure platform. Based on ELI's experience running other home visiting programs the past 12 months, parents of young children actually appreciate the flexibility that virtual visits offer and both parents are more often in attendance. Our Early Start program, for example, serving children birth to three years old, has lost less than 10% of previously enrolled clients using these adaptations. ELI has developed an entire set of safety protocols – listed in Appendix C.

As noted earlier, Instructions Not Included© makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population. **The selected approach of screening for paternal PPD and ACEs is the innovation. Doing this in the home is appropriate based on the research of general home visiting programs traditionally used as a public health intervention. Home Visiting programs offered to first time parents have shown to have positive outcomes in the areas of child health and safety (for example, well-child and dental visits, number of injuries, and emergency room visits). Traditional programs strive to alter parenting behaviors such as responsivity, sensitivity, and harshness, as well as to improve the quality of the home environment and maternal mental health. These programs have been shown to have positive effects on children's well-being. [3]**

We estimate the numbers of individuals expected to be served annually to include 450 fathers. We arrived at this number based on the following known factors: Sonoma County has approximately 1800 births per year to first-time parents. Based on community program reports, 25% of these parents are already enrolled in some type of support service. Another 25% will refuse the service. That leaves approximately 900 families to serve with this program each year. If we get 900 families participating, we anticipate that only approximately 50% of the fathers will complete all five of the visits offered in the program. Each father will receive two screenings: one PPD and one ACEs over the course of the program year.

INI will specifically target first-time fathers. According to the Sonoma County Public Health Birth Census report, 54% of first-time parents identify Spanish as their primary language spoken at home. Our typical client for this program will be mid-20s to mid-30s. One or both members of the family will be working. This family will likely be renting, will possess at least a high school diploma and may be involved with the child-welfare system. They will also likely have some form of transportation. ELI is prepared to serve both English and Spanish speaking households (and other less common languages, with interpreters) with bilingual and bicultural Developmental Specialists. Enrollment is limited to those with a Sonoma County address. Visits will be conducted at times convenient for both parents.

Outreach and engagement to new parents will include traditional outlets, such as building relationships with labor and delivery departments in the three local hospitals, pre-natal education classes, notifications to agencies such as WIC (Women, Infants and Children) programs, health fairs, and through local Mom's playgroups. In addition, information about the new service for new Fathers will be posted on social media and the ELI website.

RESEARCH ON INN COMPONENT

The unique combination of screening first time fathers for both paternal postpartum

depression (PPD) and ACEs during home visits distinguishes INI from other similar projects. Sonoma County offers multiple home visiting programs for parents of children birth to 5 years old. The vast majority of these programs serve mothers, or the children, as primary clients. These include (not an exhaustive list): Nurse Family Partnership; Healthy Families; Public Health Nursing; CPI's Perinatal Mood Disorder Program; Petaluma People Services Perinatal Mood Disorder Program. All of these programs strive to strengthen the capacity of parents to care for their young child and some may include screening for maternal depression. None of these programs screen fathers (or male partners) for PPD or ACES. The primary problem this project wants to solve is the lack of screening and early identification of perinatal mood disorders in new fathers and a resulting lack of understanding of the magnitude of the problem in Sonoma County. By not having the data, there continues to be a lack of prevention and early intervention services in Sonoma County that target the needs of new fathers and engage them in the care of their child and partner from the very beginning.

Extensive research, both on the web and with informational interviews, to investigate existing models or approaches for parents beyond Sonoma County resulted in the discovery that the majority of home visiting programs for new parents were really focused on the new mom. There are several research studies and reports about the importance of including fathers in home visiting, and some, like the Nurse-Family Partnership, have changed their protocol to include fathers, if the father is interested. However, none of the research studies seemed to find or comment on programs that specifically noted the inclusion of screening fathers for PPD/ACEs.

The 'Home Visiting: Approaches to Father Engagement and Fathers' Experiences' Study was a qualitative project by the Urban institute that collected information about innovative approaches used by existing home visiting programs to actively engage and serve fathers, and gather fathers' perspectives on participating in such programs. https://www.acf.hhs.gov/opre/research/project/home-visiting-approaches-to-father-engagement-and-fathers-experiences. This study provides insight into some of the barriers experienced, particularly with young minority fathers and offered stronger engagement strategies.

A report from the University of Chicago cites the following findings: "Beyond specific program adaptations and enhancements to better fit the challenges mothers face in their parenting, however, the field of home visitation as a whole has largely overlooked the major role that fathers play in young children's developmental outcomes, and in configuring home visiting services to address this role. It is rather startling to note, for example, that none of the (MIECHV) home visitation models that have been rigorously evaluated have been designed to target fathers as primary service recipients, none were designed to address the array of father-related influences on children's well-being, and none have yet included fathers as subjects of study. This is an especially significant oversight: A growing body of evidence has indicated that fathers play a central role in the development of young children, influencing a variety of critical outcomes for later life."
https://web.archive.org/web/20130910093611/http://www.pewstates.org/uploadedFiles/

PCS_Assets/2013/Father_Involvement_report.pdf

On the other hand, research on male PPD is growing and indicates that fathers experience postnatal mood disorders at alarming and surprising rates. A study in the Journal of American Medicine found that 10 percent of men showed signs of depression from the first trimester of their wives' pregnancies through six months after the child was born. The number increased to 26 percent during the three- to six-month period after the baby's birth. The study also found a positive correlation between paternal depression and maternal depression. [4] Postnatal mental health of fathers is reported to have various effects on the health of the whole family. Research shows that paternal depression decreases father involvement and engagement with infant children and may increase father-child conflict when children are older. Father engagement, positive attitudes about fathering, and interest in providing care can decrease fathers' parenting stress after the birth of a child. Positive father involvement can also mediate the effects of maternal depression and maternal parenting stress on children, even if the mother and father are no longer together. Positive father involvement can also lower infant distress.[8 -15]

A recent pilot study evaluated *Dads Matter*, a curriculum for father involvement within the context of standard home visiting services. Preliminary trends indicated the potential benefit of the *Dads Matter* service enhancement: (1) improved mother–father relationship quality, (2) increased father involvement with the child, and (3) decreased father-reported parenting stress and child-related problems [16]. Other research shows that home visiting may reduce the incidence of intimate partner violence [16] and that father involvement may indirectly promote the success of home visiting; in one study mothers were more likely to remain involved with the program when their partners were engaged in services. [17] None of the home visit programs studied had added paternal PPD or ACEs screening to the visits, even if they were trying to engage fathers more directly.

Depression Symptoms in Men When men experience depression, their symptoms can look different than women's depression symptoms. Women experienced four symptoms at significantly greater rates than men: stress, crying, sleep problems, and loss of interest or pleasure in things they usually enjoy. The same study found that men experienced the following symptoms at significantly higher rates than women: anger attacks/aggression, substance use, and risk-taking behavior.[19]

The American Academy of Pediatrics (AAP) also reports men are more likely to present with symptoms of substance use, domestic violence, and undermining breastfeeding instead of sadness. Chart below outlines the difference in "typical" depressive symptoms and those experienced by men.[20]

Classic Symptoms of Depression	Symptoms of Men's Depression
• Depressed, sad mood • Loss of interest or pleasure • Significant weight loss or gain • Trouble sleeping or over-sleeping • Restless feelings and inability to sit still or slow down • Fatigue, loss of energy, or tired all the time • Worthless or guilty feelings • Impaired concentration and difficulty making decisions • Recurrent thoughts of death or suicide	• Increased anger and conflict with others • Increased use of alcohol or other drugs • Frustration or irritability • Violent behavior • Losing weight without trying • Isolation from family and friends • Being easily stressed • Impulsiveness and taking risks (i.e., reckless driving and extramarital sex) • Feeling discouraged • Increase in complaints about physical problems (i.e., headaches, digestion problems or pain) • Problems with concentration and motivation • Loss of interest in work, hobbies, and sex • Working constantly • Increased concerns about productivity and functioning at school or work • Fatigue • Experiencing conflict between how you think you should be as a man and how you actually are • Thoughts of suicide

Research on PPD screening tools currently available have found that the widely recommended *Edinburgh Postnatal Depression Screen* (EPDS) scoring must be modified to be sensitive to male cultural norms, timing of the screen, and the differences in symptoms experienced by men. For example, question 9 on the EPDS is, "I have been so unhappy that I have been crying." While crying could be a symptom experienced by fathers, they are not as likely to cry as to become aggressive. Additionally, men may be less expressive about their feelings than women, thus, fathers are likely to score lower in the self-reported screening.[21] **Therefore, screenings conducted using the EPDS in the INI project will be using the recommended modified scoring scale.**

LEARNING GOALS/PROJECT AIMS

Currently in Sonoma County there are no services that specifically include screening for male postpartum depression (PPD) nor targets the emotional experience of a new father. Fathers are also not routinely screened for Adverse Childhood Experiences (ACEs), even though we know that this score can impact a parent's overall resiliency. Both of these conditions – PPD and a high ACE score – are known to contribute to the potential for child maltreatment and/or neglect. By screening for both conditions, we can learn more about the prevalence of their co-occurrence in Sonoma County and the magnitude of the problem.

The following learning goals have been defined for Instructions Not Included:

1) What percentage of new fathers are engaged in the INI home visiting program and complete both the PPD and ACEs screenings offered?
    a. Our estimates are that 50% of fathers will participate in PPD and ACEs screening. This is a priority as we would like to increase the accuracy of our estimates.

2) Identify the rate of paternal PPD in Sonoma County.
    a. Track screening scores using demographics: age, ethnicity and geographic location.

3) Identify availability of appropriate paternal PPD support, education and counseling resources in Sonoma County
    a. Track referral outcomes made to key resources including wait lists, geographic location, other noted access barriers

4) Identify the rate of high ACE scores in new fathers in Sonoma County.
    a. Track screening scores using demographics: age, ethnicity and geographic location.

5) Identify availability of appropriate paternal ACE support, education and counseling resources in Sonoma County.
    a. Track referral outcomes made to key resources including wait lists, geographic location, other noted access barriers.

6) Identify the co-occurrence of paternal PPD and high ACE scores.
    a. Compare screening scores of project participants using demographics: age, ethnicity and geographic location.

All of the learning goals relate to our goal of offering first-time fathers screenings for paternal PPD and ACEs. The goals will also help us know how many target clients engaged in the home visits so we can accurately expand or contract the program. By collecting data on fathers who accepted both the screenings and followed up on referrals made, we can support the planning for future services in our community and influence public policy throughout the state, possibly the country. As we improve our understanding of the prevalence of PPD and high ACE scores, and how to best to serve fathers within the context of home visiting, we will share this information with community partners such as First Five Sonoma County, Health Action and the Upstream Portfolio, and the Behavioral Health Division of the Department of Health Services. Incorporating these lessons into existing programs, instead of only expanding this pilot program, strengthens all home visiting programs in a cost-effective manner.

EVALUATION OR LEARNING PLAN

The following data collection tools will be used to measure the achievement of six stated learning goals.

Learning Goal #1: Percentage of new fathers are engaged in the INI home visiting program and complete all home visiting sessions and both the PMD and ACEs screenings offered.
DATA COLLECTION:

- Persimmony, a secure web-based data program will document all INI participants' demographic data and home visit record logs. Only home visiting staff and management will have access to these electronic records.
- Home visit record logs include data items such as topics of interest, general items about length of visit, unusual questions, concerns or crisis reports. In addition, cancellations and program attrition, are noted in the home visit record logs.
- All outreach efforts will be coded for tracking and will be part of initial intake questionnaire.
- Tracking system of referrals to program will be utilized, to better inform strategies of recruitment. (I.e. keep track of what works). All outreach efforts will be coded for tracking and will be part of initial intake questionnaire.
- Completion of PPD and ACEs screenings and corresponding scores will be documented.

Learning Goal #2 & #3: Rates of paternal PPD and referrals to key community resources (or lack thereof) utilized by father.
DATA COLLECTION:

a. Completion of PPD screenings and corresponding scores will be documented on home visit record logs.
b. Scores will be entered into excel tracking sheet with demographics. This will allow for sorting and cross analysis reporting.
c. Follow up on referrals to community-based services made during home visits will be part of the record log. Home visitors will gather information on success of referral, lack of needed services, wait times, barriers to access and/or client reasons for non-acceptance of MH service/referral. Information will also be entered into Excel spreadsheet for cross analysis.

Learning Goal #4 & #5: Paternal ACE scores and referrals to key community resources (or lack thereof) utilized by father.
DATA COLLECTION:

d. Completion of ACE screenings and corresponding scores will be documented on home visit record logs.
e. Scores will be entered into excel tracking sheet with demographics. This will allow for sorting and cross analysis reporting.
f. Follow up on referrals to community-based services made during home visits will be part of the record log. Home visitors will gather information on success of referral, lack of needed services, wait times, barriers to access and/or client

reasons for non-acceptance of MH service/referral. Information will also be entered into Excel spreadsheet for cross analysis.

Learning Goal #6: Identify the co-occurrence of paternal PPD and high ACE scores. Compare screening scores of project participants using demographics: age, ethnicity and geographic location.

DATA COLLECTION:

a. All Scores entered into excel tracking sheet with demographics will analyzed for correlations, including potential impact on referral follow-up.

Additionally: All clients may complete a pre and post ***Nurturing Skills Competency Scale (NSCS)***; or may be given *The Nurturing Quiz*. The NSCS is an inventory designed to gather information, both past and current, about individuals and their families in order to alert professionals about potential on-going conditions that could lead to the initial occurrence of child maltreatment. The Nurturing Quiz is an informal multiple-choice inventory given pre and post intervention designed to measure knowledge parents have of appropriate parenting practices. The Nurturing Quiz is easy to score and provides useful information regarding gains in knowledge the participants made.

Annual program evaluations will use all this data to show basic program counts (clients, including demographics; visits conducted; referrals complete/incomplete), client comments (value of program, reasons for drop out, etc.). Evaluations will also look at changes in NSCS (see above) from beginning to end of visits in an attempt to quantify parental changes.

Clients will receive follow up surveys via email (or in-person if enrolled in ongoing WMG services) that attempt to assess contact with child-welfare system, marital security and an ACEs screening for their child. These surveys will continue annually until the child reaches Kindergarten. Community indicators of child-abuse and neglect will be tracked over the same 5-year period. This 5-year follow up will allow us to see if changes made initially during the home visiting year continue to provide protective factors longitudinally. Minimal cost for this follow up is the data input costs (personnel) of the returned surveys. Data input is already included in the 3-year budget. ELI general fund will cover these costs after the conclusion of the INI 3-year program.

MHSA REGULATORY REQUIREMENTS

CONTRACTING AND COMPLIANCE

Sonoma County Department of Health Services (DHS) will contract with Early Learning Institute (ELI) for the proposed three-years of Innovation funding. ELI will develop a sub-contract with an outside third-party evaluator. ELI currently works with Sonoma State University personnel on another evaluation project and will consider engaging the same team for Instructions Not Included.

The MHSA Coordinator of the Sonoma County DHS Behavioral Health Division will be the main point of contact to monitor progress of Instructions Not Included and support for the Early Learning Institute (parent agency, community-based non-profit). Support may include connecting the project personnel to appropriate resources in the community, technical support in program delivery and evaluation, and quarterly 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, ELI 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).

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 B 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 indicates 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 regarding preparing the Innovation projects proposals for public review and appropriate approvals from local and state authorities.

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 out to

MHSA Steering Committee members, MHSA Stakeholder Committee, over 2000 contacts on the MHSA Newsletter list, County staff and contractors and any other interested parties.

NOTE: The County is proposing two projects that support new parents: New Parent TLC and Instructions Not Included. While both of these programs aim to support new parents and identify parents with symptoms of depression, they are completely different and require different types of service providers and skill sets.

New Parent TLC is training the community that comes into contact with new parents, and does not work directly with parents. It is based on a community suicide prevention training model. Gatekeepers are trained about the signs and symptoms of postpartum depression and how to talk to a new parent about what they are noticing and provide them with referrals.

Instructions Not Included is working directly with new fathers, and trained professionals are screening new fathers for depression and ACEs and providing warm hand offs to appropriate referrals.

	New Parent TLC	Instructions Not Included
Description	**Providing gatekeeper training: TLC (which is like QPR) for the community that interacts with new parents**	**Providing in home or virtual visits to new fathers and screening for post-partum depression and ACEs.**
Target Population	**childcare providers, cosmetologists and peer to peer workers**	**New fathers**
Contact with parent	**No**	**Yes**
Providing referrals for new parents	**Yes**	**Yes**

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. This is described on page 5 and again below:

The development of this program originally grew from the intersection of three things: 1) multiple requests from the community to provide home-based support for ALL first time parents and 2) growing body of research on male PPD and impact of Father's ACE score on child/family functioning; 3) A specific request from a 1st time father who lost his wife to suicide due to PMD. He felt that he did not have the knowledge, support or resources he needed that could have used to help himself or his family.

Based on this, the population to be served was also consulted for this program. In three separate focus groups held by the Early Learning Institute in August and September of 2019, mothers and fathers of children less than a year old were

queried about the supports they received, both before and after the birth of their first child. Each group independently identified that the Father received less preparation and early support and that the mother was the primary focus of support and monitoring after the birth. Interestingly, when the focus groups were split into separate Father/Mother groups, most of the fathers were far more forthcoming about how hard the first 6 months of the child's life was for them. One father said, "I wish I had known more about all the postpartum feelings that dad's get. I thought I was supposed to feel jealous of the baby. Instead, I felt terrified and weepy – I would stay at work later and later trying to get grounded and feel like I had control of something." Another father spoke of his need to "hit" stuff. He said he spent hours at the gym because he was afraid hurting his wife or baby. Of the 30 Father's interviewed, only two had initiated couples-counseling and one had starting working individually with a therapist. Four fathers were currently separated from their partners. When asked to identify, on a scale of 1 – to-10 with 10 being high, what they had heard, read or knew about Paternal Postpartum Depression, the average score was "3", with a high of "5" and a low of "0". More than 50% of fathers in our focus group said they would like to, or be willing to, participate in a "first time parent" home visiting program with their partners. 24% indicated they would be willing to participate in a home visiting program without their partners.

MHSA GENERAL STANDARDS

A) Community Collaboration

Instructions Not Included has been developed and will be implemented through a community collaboration that includes new parents, child development experts, community-based providers supporting new parents and mental health clinicians.

B) Cultural Competency

The parent organization, Early Learning Institute, works with a multicultural review team that consists of bi-lingual/bi-cultural representation from a variety of Central and South American ethnic community members. In addition, parents from the adoption community, grandparents, LGBTQ+ and parents of special needs children are represented on the review team. This community group will support the implementation, evaluation and community connection to assure a high level of cultural competency in the project.

C) Client-Driven

Home visitor logs will include documentation of parent's topics of interest and response to home visits. Notes will track attendance and follow-up with referrals. If barriers are noted, solutions generated will be developed with the parents taking the lead to promote ownership of solution.

D) Family-Driven

The project, as a whole is family-driven as both parents are included in the service provided. Date/time of home visit appointments will be set with the family's schedule in mind. Topics discussed and resources brought forth are also driven by the family's self-stated needs.

E) Wellness, Recovery, and Resilience-Focused

The project is based on philosophy promoting wellness, recovery and focused on resilience. All screening tools, PPD, PMD and ACES are geared for early identification of risk factors. Community resources will all be focused on strengthening protective factors and supporting the family to mitigate any acute/chronic mental health issues.

F) Integrated Service Experience for Clients and Families

By providing community referrals with a warm handoff and follow-up to assure a smooth transition in accessing additional services, it is expected that families will have an integrated service experience.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

All materials, including evaluation surveys and tools, will be available to participants in their native language, validated for an accessible literacy level and will be administered with assistance, as needed. Surveys and other tools will be vetted by ELI's multicultural review team, for word choices and appropriate phrasing of questions prior to use in the program. The multicultural review team is a standing committee of the Agency made up of volunteers with different backgrounds to vet different elements of all ELI programs. Currently this committee has members from Mexico, Peru, and Nicaragua who are bilingual as well as members from California and South Africa who are not. The committee has male and female parents and nonparents who represent: the adoption community; LGBTQ community; traditional family community; parents of special needs children and grandparents parenting again. The committee meets quarterly or as needed.

Feedback from program participants about the data collection and evaluation elements will be solicited and tracked. Evaluation modifications will be made based on input. All program participants will have the option of providing anonymous feedback and/or of opting out of data markers (race, language, etc.) All surveys will allow for self-identification of gender and race and will have a "decline to state" option.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

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 ELI Leadership and look holistically at the success of the project. Key indicators include the ability to engage target participants; successful outcomes of participants (as indicated on surveys and interviews), community resource information, and utilization in community mental health/support services. Also consideration will be given to success of early identification of depression, ACE understanding and amelioration; and percentage of CPS involvement of INI participants as compared to overall community percentage.

Data driven decision-making will determine if the project is promising and additional time is indicated to further develop definitive results for the project. If necessary, a criteria will be developed to determine if this project should be extended for up to two years with continued Innovation funding (up to five years total) or supported with alternative funding. 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. 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.

It is not anticipated that individuals with a serious mental illness will receive services from INI as we are not targeting this population. However, there is definitely a potential overlap as the entrance criteria is being a first-time parent in Sonoma County. All participants will receive supportive navigation to other services as needed. If a parent with serious mental illness is accessing INI services at the end of the project's final year, case management will work closely with the County BHD and community mental health services to assure an appropriate and smooth transition.

COMMUNICATION AND DISSEMINATION PLAN

A final program report will include key findings and recommendations, including those that can be integrated into other existing home visitation programs. This report will be disseminated to all First Five County Commissions with a presentation to the State First Five Commission. Presentations will also be made at partner hearings and roundtable meetings, such as County Board of Supervisors; First 5 Sonoma County; Mental Health Board; MHSA Contractors, Maternal Child Adolescent Health Board, North Bay Regional Center Early Start Meetings, Health Action Chapters, ACEs Collaborative and Sonoma County Office of Education operators. We will also disseminate our key findings and recommendations through electronic channels and in the form of news articles and press releases. The multicultural review team will contribute to the development and dissemination of a "parent friendly" version of the findings as a way of

encouraging continued participation and support for this project in our community.

KEYWORDS for internet-based search

- Home Visiting with Fathers
- New Fathers
- Male PPD Depression Screening
- Parenting and ACEs

TIMELINE

Instructions Not Included is expected to start actual home visits in 2021.The total timeframe of the INN Project will be three years from July 2021 through June 2024. This timeline is contingent upon scheduling public review and hearing and approval by MHSOAC Commission.

Project Planning and Development will begin with training the staff during the months of July and August 2021. Curriculum development, paperwork and evaluation data gathering tools will also be completed during this period.

During the first and second quarter of the Project, (July – December 2021), project planning will commence and refinement of paperwork and data collection will take place. Outreach efforts will also be enhanced as soon as notification of award takes place. Engagement plans include presentations and referral forms available to childbirth education classes; health providers (including mental health); child-welfare partners; Facebook-Twitter-Instagram and other social-media outlets that new parents are known to frequent.

Home visits and data collection is projected to commence in early September, 2021 and is an ongoing activity through the duration of the funding. Data entry will be done weekly, to ensure accuracy and timely reporting.

Evaluation reports will be published annually in the second quarter of each fiscal year. A final evaluation report will be published after the end of the Project: June 2024. Half – year interim reports will also be published during the month of December (2021, 2022 and 2023) to be used as a guide for project adjustment or design revision, as needed.

Project results and lessons learned will be disseminated annually, projected for June 2022, 2023 and 2024. Reports will be circulated and presented to community partners, stakeholders, client groups and other interested parties. ELI staff will be available for Project presentations at the request of the Behavioral Health Department and the MHSA Coordinator for as long as deemed necessary.

	Q3 2021	Q3/4 2021	Q4 2021	Q4 2021	Jan - Mar Q1 2022	Apr - Jun Q2 2022	Jul - Sept Q3 2022	Oct - Dec Q4 2022	Jan – Mar Q1 2023	Apr - Jun Q2 2023	Jul - Sept Q3 2023	Oct - Dec Q4 2023	Jan - jun Q1 & 2 2024
• Award of Innovation Project(s) • Begin Innovation Project	X												
Project Planning and Development *Training and curriculum building will be completed by Sept 2021. Home visiting will commence upon completion of contract. New Screening tool will be developed by Oct 2021.*	X	X											
Community Engagement *Recruitment will begin as soon as notification of award takes place. Engagement plans include childbirth education classes; Health providers (including mental health); child-welfare partners; Facebook; Twitter; Instagram and other social-media outlets.*	X	X	X		X		X		X		X		FINAL REPORT 6/24
Project Implementation – *Home Visiting will commence as soon as contracts are in place and will be ongoing for three years.*		X	X	X	X	X	X	X	X	X	X	X	x
Evaluation – *Data collection will happen monthly. First evaluation will take place at year end, 2021 and will be done annually. "Mini" evaluation reports will also be done every 6 months and used as a guide for program design revisions, as needed.*			X	X 12/21	X	X 6/22	X	X 12/22		X 6/23		X 12/23	X 3/24
Dissemination of Results *Results will be published in March, 2022, 2023 and 2024. Report will be circulated based on input from MHSA coordinators*												X	X

BUDGET 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 *Instructions Not Included*, 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.

ELI's Instructions Not Included has total budget of $1,091,860. The Innovation fund request is for a total of $689,860 for a three-year project that spans three fiscal years (July1 – June 30th -- 2021/22, 2022/23 and 2023/24). The annual Innovation fund budget ranges from $116,563 in Year 1; $227,639 in Year 2; $228,832 in Year 3; and $116,820 in Year 4.

The balance of $405,000 in revenue for the project is provided by the Chiat Foundation at $100,000 per year for 3 years and a donation pledge from Morton and Bassett Foundation at $35,000 for the next 3 years with potential extension. ELI will use these matching funds to provide program management support (.5 FTE @ $38064 per year plus $8,374 indirect costs); operational overhead, typically 15% of program costs ($48,060) and parent stipends ($2000/year). The rest ($38,462) will be kept in reserve for unanticipated start-up costs.

After the initial 3-year program, should results be promising, ELI does plan to request an extension of innovation funding for an additional two years. (see process above under sustainability.) When the project innovation period has ended, this home visiting program should have the research and data to prove its worth as a Prevention and Early Intervention (PEI) Program, potentially funded through local MHSA dollars. Additionally, First 5 Sonoma funds children's services and INI fits within their service category of supports for new parents. Finally - there exists the potential to market the new screening tool, to create a self-funded program.

Line 1: Personnel costs - $198,224 annually

There is the potential to reach 900 families with 5 visits a year = 4500 home visits. However, there is an expected 25% attrition rate, which will result in 3375 home visits needed in a year. Caseload formula assumes 22 visits per week, per home visitor. To reach our goal, we need 3 FTE Home Visitors = 66/week x 50 weeks = 3300 HV/year. INI will be part of ELI's Watch Me Grow portfolio of programs. Staff hired into this department are all paid professional staff. Many have the lived-experience of being parents and/or having personal PPD issues but it is not a requirement to be a "peer" for this program.

The cost of home visitors is estimated to be $46,113 per year x 3 FTE home visitors = $138,339 per year in salaries.

INI will need a part-time (.5FTE) Data Entry Specialist which will cost: $21,825 per year

Program management (.5 FTE) @ $38,060 per year salary

Line 2: Direct Costs Personnel - $43,609 annually x 3 years = 130,827.
Taxes, insurance, healthcare, vacation, sick leave.

Line 5: Direct Costs Operational - $19,284 annually x 3 years = $57,852
Estimate costs for incentives (books, child safety items, growth charts, puppets, etc.) **$12,246/year.**

Mileage – Each Home Visitor is estimated to drive 100 miles per week. (Cost estimates are based on 46-week year –4600 miles per year per home visitor x 3 equals 13,800 program miles driven in a year. ELI reimburses Home Visitors .51/mile = **$ 7038/**year in mileage costs.

Line 6: Indirect Operating costs - $48,060 annually x 3 years = $144,180
Historically 15% of program cost which covers office space, computers, communication and internet costs.

Non Recurring costs: Total - $3,943
Line 8: Certificates/Training: Estimated Cost in year 1 = $1243; Estimated cost in year 3 (due to staff changes) = $1200.
Instructions Not Included will be utilizing several evidence-based screening tools: Edinburgh Postnatal Screening Tool, Parent Stress Index and the Adverse Childhood Experiences screening tool. The program will also use curriculum from Dads Matter, Parents as Teachers and the Gottman Institute's Bringing Baby Home. Home Visitors who are not already trained to use these tools and/or the curriculum programs will need 1x training. Total Training cost: $2443.

Line 9: Surface Tablets: Estimated one-time cost $1500
Given the field nature of the program, we do intend to use 4G-Tablets for the home visitors. Three Microsoft Surface Pro Tablets will be acquired through Tech-soup, a low-cost nonprofit supplier of technology. Cost will be for all three tablets. The 4G ongoing costs will be zero as the Agency already has a "block" contract and have not reached capacity in this.

Consultant Costs: $42,000
Line 11: $13,000 for year 1 and year 2, $16,000 for year 3.
ELI plans to hire an evaluation consultant for this project at a total cost of $42,000.

Currently we are working closely with Sonoma State University on a different research project and they have agreed to contract for the evaluation of Instructions Not Included. While the evaluation amount may seem like a low percentage overall of this project, existing relationships with allow us to leverage evaluation time and talent at a low cost.

Other Expenditures:
Line 14: $2,000 Annually
Annual involvement stipends will be used to reconvene stakeholder groups intermittently to ensure input into the evaluation process, outreach efforts and any course corrections that may be needed across the life of the project. Stipends are estimated to be $20 gift cards for 100 participants each year. Total cost: $6,000.

Line 15: Unanticipated Costs: $38,462 Annually.
As a new program, there is a strong possibility for as yet unknown costs to be incurred during the first few years. The most likely cost item is the potential to have more referrals and clients than anticipated, resulting in more salary hours, mileage, client incentives and stipends. Any unused funds from this line will roll over into the next year.

ELI's Instructions Not Included program has secured additional funding from Chiat Foundation of $100,000 per year for the next 3 years, with potential extension; Morton and Bassett Foundation at $35,000 secured for the next 3 years with potential extension.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	$198,224	$198,224	$198,224			$594,672
2.	Direct Costs	$43,609	$43,609	$43,609			$130,827
3.	Indirect Costs						
4.	Total Personnel Costs	$241,833	$241,833	$241,833			$725,499
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	$19,284	$19,284	$19,284			$57,852
6.	Indirect Costs	$48,060	$48,060	$48,060			$144,180
7.	Total Operating Costs	$67,344	$67,344	$67,344			$202,032
NON RECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8.	Certification/Training	$1,243	0	$1,200	0		$2,443
9.	Microsoft Surface Tables	$1,500	0	0	0		$1,500
10.	Total Non-recurring costs	$2,743	0	$1,200	0		$3,943
CONSULTANT COSTS / CONTRACTS (evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11.	Direct Costs - Evaluator	$13,000	$13,000	$ 16,000			$42,000
12.	Indirect Costs						
13.	Total Consultant Costs	$13,000	$13,000	$16,000			$42,000
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.	Annual involvement stipends	$2,000	$2,000	$2,000			$6,000
15.	Unanticipated Costs:	$38,462	$38,462	$38,462			$115,386
16.	Total Other Expenditures	$40,462	$40,462	$40,462			$121,386
BUDGET TOTALS							
Personnel (line 1)		$198,224	$198,224	$198,224			$594,672
Direct Costs (add lines 2, 5 and 11 from above)		$75,893	$75,893	$75,893			$227,679
Indirect Costs (add lines 3, 6 and 12 from above)		$48,060	$48,060	$48,060			$144,180
Non-recurring costs (line 10)		$2,743	0	$1,200			$3,943
Other Expenditures (line 16)		$40,462	$40,462	$40,462			$121,386
TOTAL INNOVATION BUDGET		$365,382	$362,639	$363,839			$1,091,860

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$217,382	$214,639	$215,839			$647,860
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$135,000	$135,000	$135,000			$405,000
6.	**Total Proposed Administration**						
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 22/23**	**FY 23/24**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$13,000	$13,000	16,000			$42,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	$13,000	$13,000	$16,000			$42,000
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	$230,382	$227,639	$231,839			$689,860
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	135,000	$135,000	$135,000			$405,000
6.	**Total Proposed Expenditures**	$365,382	$362,639	$366,839			$1,091,860
*If "Other funding" is included, please explain. Annually: $100,000 grant from Chiat Foundation; $35,000 pledge donation from Morton & Basset.							

APPENDIX A – Support for Innovative Practice

1. Upstream Investments Portfolio – review of evidence-based program offerings in Sonoma County, CA. http://upstreaminvestments.org/Find-a-Program/

2. Lewis G., Neary M., Polek E., Flouri E., and Lewis, G (2017). The association between paternal and adolescent depressive symptoms: evidence from two population-based cohorts. The Lancet Psychiatry 2017,4(12),920-926.

3. Maternal Depression in Home Visitation: A Systematic Review
Robert T. Ammerman, Frank W. Putnam, Nicole R. Bosse, Angelique R. Teeters, and Judith B. Van Ginkel

4. (Paulson JF, Bazemore SD. Prenatal and Postpartum Depression in Fathers and Its Association With Maternal Depression: A Meta-analysis. JAMA. 2010;303(19):1961-1969. doi:10.1001/jama.2010.605.)

5. Asper MM, Hallén N, Lindberg L, Månsdotter A, Carlberg M, Wells MB. Screening fathers for postpartum depression can be cost-effective: An example from Sweden. Journal of Affective Disorders. 2018 Dec; 241: 154-163.

6. Goodman, J.H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. Journal of Advanced Nursing. 45: 26-35.

7. Cameron EE, Hunter D, Sedov ID, Tomfohr-Madsen LM. What do dads want? Treatment preferences for paternal postpartum depression. Journal of Affective Disorders. 2017 Jun; 215: 62-70.

8. Cameron EE, Sedov ID, Tomfohr-Madsen LM. Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. Journal of Affective Disorders. 2016 Dec; 206: 189-203.

9. Da Costa D, Zelkowitz P, Dasgupta K, Sewitch M, Lowenstein I, Cruz R, Hennegan K, Khalifé S. Dads Get Sad Too: Depressive Symptoms and Associated Factors in Expectant First-Time Factors. American Journal of Men's Health. 2015 Sep 18; 11(5): 1376-1384.

10. Fuertes M, Faria A, Beeghly M, Lopes-dos-Santos P. The effects of parental sensitivity and involvement in caregiving on mother-infant and father-infant attachment in a Portuguese sample. Journal of Family Psychology. 2016 Feb; 30(1): 147-156.

11. Koch S, De Pascalis L, Vivian F, Meurer Renner A, Murray L, Arteche A. Effects of postpartum depression on father-infant interaction: the mediating role of face recognition. Infant Mental Health Journal. 2019.

12. Helle N, Barkmann C, Bartz-Seel J, Diehl T, Ehrhardt S, Hendel A, Nestorius Y, Schulte-Markwort M, von der Wende A, Bindt C. Very low birth-weight as a risk factor for postpartum depression four to six weeks post birth in mothers and fathers: Cross-sectional results from a controlled multicentre cohort study. Journal of Affective Disorders. 2015 Jul 15; 180: 154-161.

13. Leung BMY, Letourneau NL, Giesbrecht GF, Ntanda H, Hart M. Predictors of Postpartum Depression in Partnered Mothers and Fathers from a Longitudinal Cohort. Community Mental Health Journal 2017 May; 53(4): 420-431.

14. Saxbe DE, Schetter CD, Simon CD, Adam EK, Shalowitz MU. High paternal testosteron may protect against postpartum depressive symptoms in fathers, but confer risk to mothers and children. Hormones and Behavior. 2017 Sep; 95: 103-112.

15. Suto M, Isogai E, Mizutani F, Kakee N, Misano C, Takehara K. Prevalence and Factors Associated With Postpartum Depression in Fathers: A Regional, Longitudinal Study in Japan. Research in Nursing & Health. 2016 May 22; 39(4): 253-262.

16. Sharps, Phyllis W., Jacquelyn Campbell, Marguerite L. Baty, Keisha S. Walker, and Megan H. Bair-Merritt. 2008. "Current Evidence on Perinatal Home Visiting and Intimate Partner Violence." Journal of Obstetric Gynecologic & Neonatal Nursing 37 (4): 480–91.

17. Guterman, Neil B. 2012. "Promoting Father Involvement in Home Visiting Services for Vulnerable Families: A Pilot Study." Final Report to the Pew Center on the States, University of Chicago.

18. Eckenrode, John. 2000. "What Works in Nurse Home Visiting Programs." In What Works in Child Welfare, edited by Miriam P. Kluger, Gina Alexander, and Patrick A. Curtis, 35–43. Washington, DC: Child Welfare League of America.

19. Martin L, Neighbors H, and Griffith D (October 2013). The Experience of Symptoms of Depression in Men vs. Women: Analysis of the National Comorbidity Survey Replication.

20. Earls MF, Yogman MW, Mattson G, Rafferty J, Committee On Psychosocial Aspects Of C, Family H: Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. Pediatrics. 2019;143

21. Matthey S, Barnett B, Kavanagh DJ, and Howie P (May 2001). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners.

22. https://mullinscounseling.files.wordpress.com/2012/02/epds-for-fathers-online-version.pdf

APPENDIX A:

ELI's evidence-based home visiting program will include first time fathers incorporating three additional curricula: Promoting First Relationships, Partners for a Healthy Baby and Nurturing Fathers.

PROMOTING FIRST RELATIONSHIPS is a training program at Parent-Child Relationship Programs at the Barnard Center, at the University of Washington, dedicated to promoting children's social-emotional development through responsive, nurturing caregiver-child relationships. Service providers are trained in the use of practical, in-depth, effective strategies for promoting secure and healthy relationships between caregivers and young children (birth to 5 years). The Promoting First Relationships Curriculum covers issues critical to supporting and guiding caregivers in building nurturing and responsive relationships with children, including: Theoretical foundations of social and emotional development in early childhood (birth to 5 years); Consultation strategies for working with parents and other caregivers; Elements of a healthy relationship; Promoting the development of trust and security in infancy; Promoting healthy development of self during toddlerhood; Understanding and intervening with children's challenging behaviors; Developing intervention plans for children and caregivers; Individualizing Promoting First Relationships for your setting.

PARTNERS FOR A HEALTHY BABY: features materials for home visitors and families that promote child development and family well-being. The curriculum is organized around children's ages and topics home visitors can use to support both age-appropriate learning and family development. The Partners curriculum addresses the multifaceted needs of expectant and parenting families. Partners is a "two generational" curriculum that addresses the needs of both the parents and the child. Partners covers a wide array of issues related to Family Development and Family Health & Safety, and includes content that addresses Preparing and Caring for Baby/Toddler; and Baby's/Toddler's Development. With 671 Purposes and corresponding Parent Handouts to choose from, Home Visitors can individualize visits to address the specific needs of each family.

NURTURING FATHERS: designed to teach parenting and nurturing skills to men, this psychoeducational program has strong evidence for developing attitudes and skills for male nurturance and has been shown to be effective in changing parental attitudes and behaviors for its participants (as measured by the AAPI-2*). Additionally, it has been shown to be particularly effective with Hispanic fathers in developing appropriate expectations, empathy, and role reversal. *The AAPI-2 provides an index of risk in five specific parenting and child rearing behaviors known to contribute to child abuse and neglect (Bavolek & Keene, 2001).

APPENDIX B – SONOMA COUNTY MHSA STEERING COMMITTEE REPRESENTATION

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	Health, Community Benefits, MH	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

26%	7 consumers
41%	11 Family member
19%	5 LBGTQ+
11%	3 Latinx
4%	1 Native American
11%	3 TAY

APPENDIX C

HOME VISITING SAFETY PROTOCOLS

The following guidance is based on the most current Department of Public Health guidance. The health and safety of children, family, and staff are of the utmost importance. This guidance is not intended to address every potential scenario that may arise as this event evolves.

1. **Anyone planning an in-person home visit should contact families (by telephone, email, text) <u>prior</u> to the visit and ask about the following:**
    - **a.** Signs or symptoms of COVID 19
    - **b.** Potential contact with anyone confirmed positive or under investigation for COVID-19, or ill with a respiratory illness.
    - **c.** The immune status/risk of household members; those who have a weakened immune system, over the age of 60 years, have chronic health conditions (e.g. heart disease, lung disease, diabetes), or other COVID-19 risk factors.

    **See Brief Questionnaire below*

2. **Nothing is to be taken into homes, except essential items like keys, phone, and wallet.**
    a. ELI recommends that these items are stored in small case/bag/container that can be wiped down.
    b. Do not take in toys, mats, note taking materials, etc.
    c. Consider removing shoes and wearing "booties."
    d. Wear disposable shoe covers if you choose to keep shoes on.

3. **Minimize contact with frequently touched surfaces in the home.**
    - **a.** Wash your hands with soap and water for at least 20 seconds upon entering the home (if possible) and after exiting.
    - **b.** If soap and water are not available, use hand sanitizer.
    - **c.** Avoid touching eyes, nose and mouth, especially on the visit.

4. **Change clothing and wipe down shoes between home visits.**
    - **a.** All employees must wear clean "scrubs" (tops/bottoms) that can be easily stripped off after HV and secured in dry laundry bag until washed.
    - **b.** Change before entering car if possible.
    - **c.** If not possible, cover car seat with disable or washable cloths.
    - **d.** Wipe off shoes with sterile wipe or remove shoe covers and dispose.
    - **e.** Wash hands/use sanitizer after changing.

5. **Masks must be worn on home visits and social-distancing (6') maintained.**
    - **a.** Masks are recommended even during outside visits. However, when necessary, double-social distancing can substitute for facemasks. (12 feet)
6. **Temperature scans should be performed on adults and children in home before entering home.**
    e. Use non-touch thermometers.
    f. Visit must be cancelled if anyone has a temperature above 100.4.

7. **A few health questions must be re-asked prior to entering home.**
    - **a.** Is anyone in the home currently sick?
        i. Home visitor has discretion to assess risk of any "yes" answers. For example – if child has had an ear infection, it is OK to visit.

g. Does or has anyone had a fever?
h. Has anyone unusual visited the home in the past 24 hours?
    i. If so, what is their health profile/status?

8. **Daily schedules must be kept on cloud file and up-to-date.**

9. **All potential exposures must be reported immediately to supervisors.**

*Brief questionnaire prior to all face-to-face visits

Be sure to ask about all household members:

1) Is anyone in your household experiencing any of the following symptoms:

- Fever or chills
- Headache
- Cough
- New loss of taste or smell
- Diarrhea
- Sore throat
- Fatigue
- Congestion or runny nose
- Muscle or body aches
- Nausea or vomiting
- Shortness of breath or difficulty breathing

2) Has anyone in your household had contact with anyone who has known or possible exposure to the COVID-19 in the last 14 days?

3) Is anyone in your household on home quarantine or isolation due to possible contact with someone with possible or confirmed COVID-19 or due to travel?

4) Please tell me about the immune status/risk of household members; those who have a weakened immune system, over the age of 60 years, have chronic health conditions (e.g. heart disease, lung disease, diabetes), or other COVID-19 risk factors.

If you become aware of a confirmed or presumptively positive case, please notify your supervisor. Anyone who answers “yes” to the screening questions should be urged to consult with their health care provider immediately.

APPENDIX D - Instructions Not Included Training

Procedures:

All new home visitors, and supervisors will receive role-specific training before working independently with families to ensure they have a thorough understanding of their role within the Early Learning Institute's Instructions Not Included program. The training is conducted by staff that has been intensively trained in that role. The training includes:

- Theoretical background of staff's role
- Shadowing of other staff in a similar role
- Training on forms and form use
- Hands on-practice (with observation and feedback)
- Inter-rater reliability related to documentation (home visit documentation, parent survey summaries and scores and/or supervision documentation)
- Use of the reflective strategies, strength-based tools and interviewing techniques

Training Plan/Policy

Policy: Every ELI program has a comprehensive training plan/policy that assures access and ongoing tracking and monitoring of required trainings in a timely manner for all staff.

Procedures:

- Staff discuss their annual training goals with their supervisor during the introductory period and annual performance evaluations.
- Staff maintain training records and document all training.
- Supervisors monitor and approve training received to ensure timely access and receipt of all required training.
- Supervisors provide new staff will orientation prior to staff providing services. This orientation is to include the following: goals, services, curriculum materials, policy and operating procedures, data collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision of staff.
- All new home visitors, supervisors and program managers receive role-specific stop gap training with their direct supervisor, or designee before working independently with families, or before their first supervision to ensure they have a thorough understanding of their role within the Early Learning Institute and Instructions Not Included.
- Within three months of date of hire, staff receive training in the following areas: infant care; child health and safety; and maternal and family health.
- Within six months of date of hire, staff receive training in the following areas: prenatal issues; infant and child development; role of culture in parenting; parent-child interaction; staff related issues; and mental health.
- Within twelve months of date of hire, staff receive training in the following areas: child abuse and neglect; family violence; substance abuse; family issues; the role of culture in parenting.
- All staff receive training on child abuse and neglect annually as scheduled by the program manager.
- All staff receive training designed to increase understanding and sensitivity of the unique characteristics of the service population annually as scheduled by the program manager.
- All staff who administer or supervise staff who administer developmental screenings are trained in the use of the tool, in accordance with developer requirements, before administering it.
- All staff who administer or supervise staff who administer the depression screen/tool have been trained in the use of the tool, in accordance with developer requirements, before administering it, and supervisors also receive this training.
- All staff are trained in other evaluation tools or screening/assessment tools as appropriate.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – Sonoma County

Innovation (INN) Project Name:	**Collaborative Care Enhanced Recovery Project (CCERP)**
Total INN Funding Requested:	**$998,558**
Duration of INN Project:	**3 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 15, 2020
Public Comment Period:	November 13, 2020-December 14, 2020
County submitted INN Project:	February 4, 2021
Date Project Shared with Stakeholders:	Nov. 18, 2020 and Feb. 10, 2021

Project Introduction:

Sonoma County is requesting up to $998,558 of Innovation spending authority to work in partnership with the Adult & Aging Division within the Sonoma County Human Services Department and Santa Rosa Community Health Centers (SRCH) to increase access to unserved and underserved groups, specifically focusing on LatinX older adults to improve symptoms associated with depression.

The project will modify and utilize the Collaborative Care Model that includes care coordination that is short term (12 weeks) and will pilot and test the efficacy of using this model for a longer-term, in combination with in-home case management (an additional 9 months) that would increase the duration of the interventions to 12 months.

The Collaborative Care Model (CoCM) is a model that integrates primary care along with two additional components:

- case management for individuals who receive behavioral health treatment
- routine psychiatric consultations with the individual's primary care team.

This model may be helpful for clients whose symptoms and conditions are not improving.

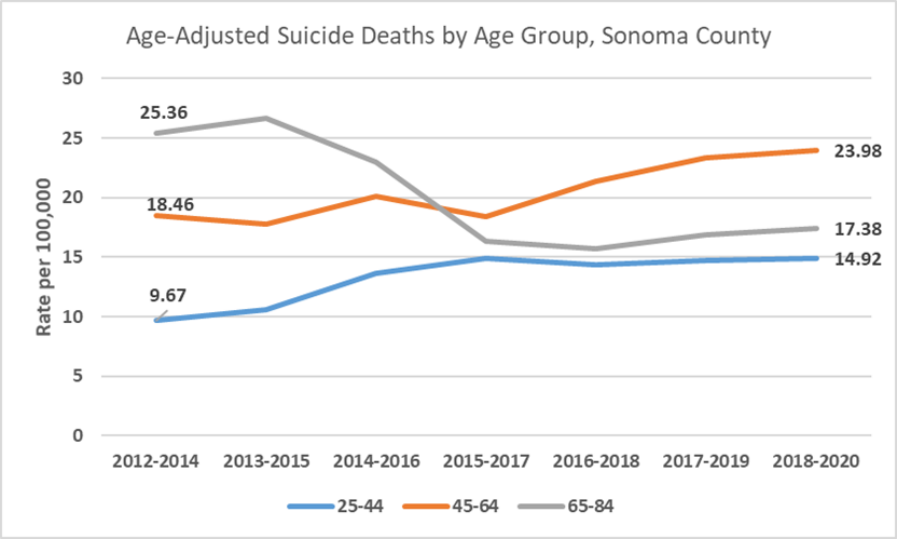
What is the Problem?

Sonoma County states they have a large aging LatinX population that is experiencing challenges related to depression, suicide, and medical health issues. Approximately 40% of Sonoma's residents are over the age of 50 and 27% of Sonoma residents are LatinX and 25% of the Hispanic population in the County speak Spanish as their primary language. Additionally, there are disparities in the utilization of mental health services and various social factors that increase depression in this population.

In Sonoma County:

- 13% of adults have considered suicide compared with 10% statewide.
- It is estimated that only 33% of LatinXs adults diagnosed with mental illness receive treatment, compared with the national average of 45%.
- Additionally, social factors such as food insecurity, substandard housing, and poverty may increase the likelihood of depression.

Sonoma County indicates they have extensive waiting lists for home-based coordination services; however, to receive these services within the County, an individual must be at least 65 years old, missing the overall depression period for adults between 50-64. The current Collaborative Care Model utilized in the County was designed and tested specifically for those over the age of 65 years (see page 12 of project plan). This project will lower the age to provide services for adults between 50-64, allowing for treatment of individuals that would otherwise be missed entirely. In Sonoma County, suicide rates for those 45-64 are increasing. This project would identify and provide services for those in that specific population.



- Rates increased for adults 25-44 and 45-64 years.
- Rates for adults 65-84 years decreased.
    - In 2014 there were an unusually large number of deaths among this age category. Once the 3-year averages excluded this year (2015 and forward) the rate adjusted back to what we would expect to see.

Additionally, the County recognizes the existing disparities in access and utilization of mental health services by the LatinX population compared with individuals identified as White.

The Adult and Aging Division (A&A) within Sonoma's Human Services Department is the largest agency serving older adults. In working with the Community to identify needs or areas of improvement, the Adult and Aging Division identified four areas the community felt needed to be addressed:

1. Increased access for services for adults aged 50-64
2. Services specifically targeting LatinX population
3. Access to home-based care coordination
4. Cross collaboration amongst programs and agencies

In response to these four areas identified, the A&A and Santa Rosa Community Health (SRCH) worked in partnership with the community to develop this project to address these areas of need.

How this Innovation project addresses this problem:

To address the needs identified by the community, Sonoma County will test the efficacy of serving older adults, aged 50-64, by combining longer term case management with the current Collaborative Care Model. The County hopes to learn if combining elements of these two approaches will result in improving outcomes for older adults living with depression. The County currently utilizes the Collaborative Care Model (CoCM) which is a short-term evidence-based approach, integrating physical and behavioral health services. The County's current CoCM program includes 12 weeks case management, regular monitoring and treatment utilizing clinical rating scales, and routine psychiatric caseload reviews and consultations for clients who are not showing clinical improvement.

To address the needs, this project will adapt the current CoCM model by doing the following:

- Extend case management services from 3 months to 12 months
- Expand the ages from 65 and over to 50 and over, targeting those most at risk for depression
- Specifically target LatinX aging adults as they are least likely to seek and access mental health services

County staff are concerned that the current 3-month model of service delivery is inadequate to meet the long-term needs of this population, and services end just as the individual is starting to feel better and is seeing improvement in their wellness. The County states that extending the existing CoCM model from three months to twelve months allows for the time needed to build personal relationships that will increase the likelihood that care will prevent relapses and maintain improvements in both physical and behavioral health.

As part of this pilot project, a CCERP care team will be implemented to include the following personnel:

- 1.0 FTE CBO Care Manager (embedded at SRCH)
- 0.5 FTE CBO Program Planning and Evaluation Analyst
- 0.1 FTE CBO Supervisor
- 0.275 SRCH Program Administrator
- 0.5 SRCH Care Coordinator/Patient Navigator
- 0.1 SRCH Primary Care Physician
- 0.013 FTE SRCH Psychiatric Consultant
- 0.1 FTE SRCH RN Case Manager
- 0.1 FTE SRCH Behavioral Health Manager Supervision
- 0.2 FTE SRCH Behavioral Health Provider

This multi-disciplinary team promotes new lines of communication, coordination, and information-sharing. Care management meetings will be held and attended by all care staff. As clients begin to show improvement in depressive symptoms over the 9-month period, their cases will be brought back for monthly or biweekly check-ins.

To address cultural responsiveness and linguistics, all social workers who serve as project staff will be bilingual in Spanish. Additionally, Santa Rosa Community Health will have bilingual representations in all positions related to this project. All community outreach, education, and printed materials will be included in both English and Spanish.

Over the year long program, individuals will gradually be phased out depending on the client and their established needs to facilitate transition to independent care. Project staff will work to coordinate resources and any supports that will assist the client in maintaining overall health and wellness. The integration of physical health, mental health, in-home visits, and case management for a year will hopefully result in the patient's overall wellbeing and sustained recovery.

Santa Rosa Community Health will pilot this project at their Lombardi Campus which currently offers primary care, mental health care, women's health, specialty care, as well as an onsite pharmacy and lab. The Lombardi Campus is in a largely LatinX populated area, currently providing services for Hispanic clients (80% of these clients are best served in Spanish). If this project is successful, the County hopes to utilize this enhanced CoCM model to the other three large SRCH campuses.

Community Planning Process: **(**see pages 17-25 of County project plan)

Local Level

Guided by the County's MHSA Steering and Stakeholder Committee, county staff and contractors, Sonoma County completed a thorough stakeholder engagement process, resulting in the development of this project. *– see page 18 of the project plan.*

The County's 30-day public comment period was held between November 13, 2020 through December 14, 2020, followed by a public Mental Health Board Hearing on

December 15, 2020. The County indicates there were no substantive comments received regarding this innovation project. Sonoma received approval from their County Board of Supervisors on February 23, 2021.

Commission Level

Commission staff originally shared this project with its stakeholder contractors and the listserv on November 18, 2020 while the County was in their 30-day public comment period with all comments being directed to the County. The final version of this project was again shared with stakeholders on February 10, 2021.

No Comments were received in response to Commission sharing of this plan with stakeholder contractors and the listserv.

Learning Objectives and Evaluation: (see pages 13-16 of County project plan)

Sonoma County's target population for this project are low-income LatinX individuals over the age of 50 who currently receive services at the Lombardi Campus. This project will also provide case management services for a year.

Based on the individuals currently served within the County's CoCM programs, Sonoma anticipates serving a minimum of 225 clients over project duration:

- Year one: 50 clients
- Year two: 75 clients
- Year three: 100 clients

The County has identified three questions relative to the evaluation and learning goals for this project:

1. For adults 50 and older whose depression symptoms improve with the existing CoCM's 12-week intervention, are these improvements sustained over the course of an additional 9-month case management period?
2. For adults age 50 and older who receive a 12-week CoCM depression intervention plus nine months of case management, is there an improvement in appropriate utilization of preventative health care, as compared to participants' health care utilization prior to the intervention (baseline) and over the course of the treatment intervention?
3. For Hispanic and Latino adults age 50 and older who receive the CCERP intervention, are there sustained depression symptom improvements and improvements in appropriate health care utilization?

Additionally, the County has also identified three learning goals and project aims to support the evaluation of this project (*see pgs 13-14 of project plan*).

The learning goals are both quantitative and qualitative in nature. Data for the learning goals will be collected throughout the program by collecting or observing the following:

- Participants will be asked to complete the PHQ-9 Depression Screening self-assessment at the following intervals: program start and then every 3 months afterward up to the one-year mark of program completion

  - These PHQ-9 scores will be compared with the individuals previous score and also compared with the depression rates for individuals enrolled in the 12-week CoCM program
- The number of participants that adopt the expanded 12-month long CoCM program, number of visits completed and length of involvement in the program
  - This will be compared with established rates for the current 3-month long CoCM program
- Data tracking of any increase or decrease in patient preventive care visits, percentage of clients that are compliant with their health screenings, and medication adherence
  - This data will be compared with the individual's previous health history as documented in the County's Community Electronic Health Record (EHR), to be utilized and accessed by the integrated care team
- Decrease in social isolation as captured by a self-assessment every 3 months during the one-year program
- Improvements in social determinants of health
  - Screening tools will be gathered in-clinic and during in-home assessments
  - Any referrals made to connect clients with resources will be tracked using EHR

The Budget

The County is requesting authorization to spend up to $998,558 in MHSA Innovation funding for this project over a period of three years, although the total project cost will be $1,261,780. Additional funding to include in-kind matching contributions and leveraging of federal funds have reduced the total amount of project to the Innovation funding request.

Funding Source	FY 21/22	FY 22/23	FY 23/24	N/A	TOTAL
Innovation Funds	$ 412,569.00	$ 346,089.00	$ 239,900.00		$ 998,558.00
Medi-Cal FFP	$ 39,029.00	$ 32,349.00	$ 22,868.00		$ 94,246.00
1991 Realignment	$ 69,666.00	$ 59,089.00	$ 40,221.00		$ 168,976.00
Behavioral Health Subaccount	$ -	$ -	$ -		$ -
Any other funding	$ -	$ -	$ -		$ -
Total	**$ 521,264.00**	**$ 437,527.00**	**$ 302,989.00**	**$ -**	**$ 1,261,780.00**

3 Year Budget	FY 21/22	FY 22/23	FY 23/24	Match	Total
Personnel	$ 421,230.00	$ 346,089.00	$ 239,900.00	$ 159,164.00	$ 1,166,383.00
Indirect Costs	$ -	$ -	$ -	$ 104,058.00	$ 104,058.00
Direct Costs	$ -	$ -	$ -	$ -	$ -
Evaluation / Consultant	$ -	$ -	$ -	$ -	$ -
Other Expenditures	$ -	$ -	$ -	$ -	$ -
Total	**$ 421,230.00**	**$ 346,089.00**	**$ 239,900.00**	**$ 263,222.00**	**$ 1,270,441.00**

The County is requesting authorization to spend up to $998,558 in MHSA Innovation funding for this project over a period of three years, although the total project cost will be $1,261,780. Additional funding to include in-kind matching contributions and leveraging of federal funds have reduced the total amount of project to the Innovation funding request.

- Personnel costs total $998,558 (79% of total project cost)
  - This amount includes salaries and benefits for all staffing in this project *(see pg. 3 of analysis)*
  - *Personnel in this project will perform the evaluation - $*228,154 (18% of total project cost)
- Indirect costs are being contributed by key partners in this project and are not part of the innovation funding request
- In-kind matching is being provided by key partners in this project:
  - Personnel: $159,164
  - Indirect costs: $104,058

The County has a total of $822,000 of Innovation reversion funds that will revert as of June 30, 2021. To ensure that reversion funds are not lost, the County submitted a total of four innovation projects for approval consideration from the Commission – all four projects were finalized and submitted in February 2021 for a total of $2,819,588 among all four projects.

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

References:

https://www.hca.wa.gov/health-care-services-supports/collaborative-care#:~:text=Collaborative%20care%20model%20is%20a%20model%20of%20behavior,team%2C%20particularly%20clients%20whose%20conditions%20are%20not%20improving.

https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Hispanic-Latinx

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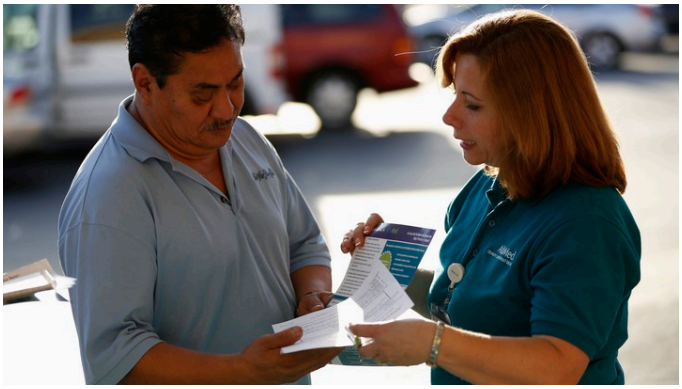
WELLNESS • RECOVERY • RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION



Collaborative Care Enhanced Recovery Project (CCERP)

Sonoma County Innovation **2021-2024** Plan Proposal

MENTAL HEALTH SERVICES ACT (MHSA) INNOVATIONS PROJECT PLAN:

Collaborative Care Enhanced Recovery Project (CCERP): Advancing Older Adult Depression Care Through Extended Supportive Services

A Project of Santa Rosa Community Health & Sonoma County Human Services Department

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
	Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose

X	Increases access to mental health services to underserved groups
X	Increases the quality of mental health services, including measured outcomes
X	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

2.A) PRIMARY PROBLEM:

Sonoma County faces an increasingly senior and Hispanic/Latino population; increases in depression, suicide and chronic health problems; disparities in culturally responsive treatment and access to care among low-income and Hispanic residents; and significant challenges in the local mental health care system. In response, the County of Sonoma Human Services Department (HSD) Adult and Aging Division (A&A) and Santa Rosa Community Health (SRCH) propose a pilot project to improve treatment for older adults struggling with depression. The *Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)* will augment an established short-term intervention model with longer-term, in-home case management and target it to the underserved Hispanic/Latinx population, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression.

Demographic Profile: Sonoma County as a whole is experiencing a profound demographic shift, mirroring that which is underway throughout the state and the nation, as the population ages and demand for behavioral health services grows among older adults. Sonoma County's percentage of aging adults continues to grow faster than the US average and makes up a significantly larger share of the total population than the state average: 39.1% of the County's approximately 504,000 residents are over the age of 50, compared to

31.6% for the state.[1] Further, the number of residents aged 60 and older is projected to increase by nearly 38% between 2015 and 2025.[2]

Hispanic/Latino individuals also make up a growing proportion of the population of Sonoma County: 27% of the County's population is Hispanic and 62.1% is white.[3] Correspondingly, more than a quarter of County residents speak a primary language other than English, 77% of which is Spanish.[4] Further, as the largest city in Sonoma County and the biggest urban center between San Francisco and Portland, Santa Rosa is home to a disproportionate share of low-income Sonoma County residents struggling with unaddressed mental health disorders, chronic disease, and contributing social determinants of health.

Health & Well-Being Risks: Older adults are at increased risk of being socially isolated or lonely, leading to depression, and other health concerns, including high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death.[5] A PubMed literature review examining research into the risk-factors for suicide in older adults identified a range of causes, from psychiatric disorders or cognitive impairment to social exclusion, illness and physical or psychological pain.[6]

It is adults 50+ who have the highest rates of depression and a greater suicide risk than any other age group. In 2017, the highest suicide rate in the nation (20.2/100,000) was among adults aged 45 to 54, followed closely by those aged 55 to 64 (19/100,000).[7] Local rates for contemplating suicide are higher than in the state; 13% of Sonoma County adults have considered suicide, compared to 10% statewide.

The correlation between depression and chronic disease is also clearly documented. Depression and diabetes, for example, co-occur twice as frequently as would be predicted by chance. When diabetes co-occurs with depression, the outcomes for both conditions are compounded, and one's capacity to self-manage the disease decreases while the likelihood of complications increases.[8] Patients with poor control of their diabetes are at high risk for complications such as blindness, end stage renal disease, amputation, and significantly reduced longevity and quality of life.

Unfortunately, the rate for certain chronic diseases like diabetes is higher in Santa Rosa than in the county or state.13% of Santa Rosa Community Health (SRCH)'s adult patients[9] have a diagnosis of diabetes mellitus (DM), compared with 9% in CA and 10% in Sonoma County. Of those SRCH patients with DM, 34.6% had A1c (blood glucose level) greater than 9% in 2018, which indicates very poor control over the disease and also places SRCH and its patients in the third performance quartile among all US health centers. Of those individuals with poor DM control, 681 (61%) are Hispanic, and 422 (37.9%) are non-Hispanic (N=1113).[10] In short, diabetes with all its potential physical and mental health impacts is 73% more prevalent in SRCH's Hispanic/Latinx patients.

There are also notable disparities in the availability and utilization of mental health services among the immigrant and Hispanic population. Only 33% of Hispanic and Latino adults diagnosed with mental illness receive treatment each year compared to the national average of 43%,[11] and Hispanic and Latino individuals

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[1] 2013-2017 American Community Survey Estimates

[2] California Department of Finance. http://www.dof.ca.gov/Forecasting/Demographics/projections/

[3] Ibid

[4] Ibid

[5] National Institute on Aging. Social isolation, loneliness in older people pose health risk. 2019. https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5916258/

[7] American Foundation for Suicide Prevention, 2019. https://afsp.org/about-suicide/suicide-statistics

[8] Holt, R. I., de Groot, M., & Golden, S. H. (2014). "Diabetes and depression." Current Diabetes Reports, 14(6), 491. doi:10.1007/s11892-014-0491-3

[9] The term "Patients" is used in this document in reference to those served at Santa Rosa Community Health (SRCH). Since this proposed project is a collaborative model, the term "client" will be interchangeable with reference to patients of SRCH.

[10] Santa Rosa Community Health, 2019

[11] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

also face cultural barriers to mental health care, in particular late-life depression care.[12] SRCH and other Federally Qualified Health Centers are also observing a decline in Hispanic/Latino mental and physical health care utilization in the wake of the final rule on public charge due to immigration fears, regardless of an individual's immigration status.[13]

Social Factors: It is important to note that social determinants of health play a significant role in older adult depression, heightening the urgency for increased services, especially as the aging population in Sonoma County grows. The likelihood of depression increases as household income decreases. 15.8% of families below the FPL had depression, but only 3.5% of adults living at/above 400% of the FPL had depression.[14] In Sonoma County, nearly 14% of residents over age 60 live below 150% of the federal poverty level (FPL), often in communities with substandard housing, geographic isolation, inaccessible transportation, lack of access to supportive services, food insecurity, crime, and/or violence.[15] A combination of two or more such factors places older adults at risk of decreased quality of life, poor health and social outcomes, and high susceptibility to abuse and neglect. These factors are also correlated with heightened occurrence of depression among the aging population.[16] Among SRCH patients, poverty and other social determinants of health are even higher. 97% of SRCH patients live at or below 200% of FPL and 78.6% live at or below 100% of FPL.

The risk for depression is even greater among low-income, Hispanic/Latinx people. Hispanic/Latinx and Spanish-speaking individuals living below the poverty level are 200% more likely to report psychological distress than those over twice the poverty level.[17] In addition, feelings of anxiety, frustration, fear, and stress have increased in more than half of immigrant families since the 2016 election.[18] This is compounded by social stigma around accessing mental health care. Nationally, only 33% of Hispanic and Latino adults with mental illness receive treatment each year compared to the national average of 43%.[19] Undocumented Latinos were the least likely to have seen a mental health professional in the past year and were unlikely to seek mental health treatment due to cost.[20]

Access to Mental Health Care and Supporting Services: Current local community needs surveys identified access to mental health care as a top priority. In Kaiser Permanente's 2019 report for Santa Rosa, community stakeholders stated a need for increased accessibility to mental health services, but also to reduce stigma around mental health issues. This is heightened by the fact that rates of depression, hopelessness, and anxiety reportedly doubled among at least one member of households in the year following the 2017 wildfires.[21] The majority of the residents who perished in the 2017 fires were older adults, and hundreds were displaced by the destruction of the senior mobile home park Journey's End. Given the 2019 Kincade fire, repeated Planned Safety Power Shutoffs by Pacific Gas & Electric, two wildfires in 2020 to say nothing of COVID-19, these priorities will likely remain the same or very probably increase.

Disturbingly, the 2019 California Future Health Care Workforce Commission report highlights a looming crisis in the workforce supply for primary care and mental health services.[22] The Commission estimates that by

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[12] Hoeft, T; Hinton, L; Liu, J; Unutzer, J. "Directions for effectiveness research to improve health services for late-life depression in the United States." American Journal of Geriatric Psychiatry. 2016 Jan; 24(1): 18-30.

[13] CalMatters. Immigrants afraid of Trump's 'public charge' rule are dropping food stamps, Medi-Cal. 22 September 2019. https://calmatters.org/california-divide/2019/09/immigrants-afraid-trump-public-charge-rule-food-stamps-medical-benefits/

[14] CDC. Prevalence of Depression among Adults Aged 20 and Over. https://www.cdc.gov/nchs/products/databriefs/db303.htm

[15] Ibid

[16] Sonoma County Human Services Department. The Art of Aging in Sonoma County, 2015

[17] U.S. Department of Health and Human Services, Office of Minority Health https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=69

[18] California Pan-Ethnic Health Network. Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. 2019

[19] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

[20] Ibid

[21] Kaiser Permanente. 2019 Community Health Needs Assessment. Kaiser Foundation Hospital: Santa Rosa, 2019

[22] California Future Health Workforce Commission. Meeting the Demand of Health: Final Report of the California Future Health Workforce Commission. February 2019, https://futurehealthworkforce.org/

2030 California will have a 40% deficit in the psychiatric workforce to cover California's needs. This workforce shortage is disproportionately represented in rural communities and mirrors the crisis seen across the nation. Sonoma County has not been immune to this alarming trend and continues to carry a designation as a Health Professional Shortage Area (HPSA) for both primary care and mental health services. HPSA scores are the leading federal indicator for critical labor shortages in meeting the need for medical, dental and mental health care in a U.S. city or region. SRCH has a mental health HPSA score of 19, up by two points in the last three years, and a HPSA primary care score of 18.[23] So, while the need for mental health services is increasing, the number of professionals trained to deliver such services is facing a dire shortage.

In its capacity as Sonoma County's largest agency focused on serving older adult clients, Adult & Aging (A&A) has observed long waiting lists for existing home-based care coordination programs, a vital way to address the risks and social determinants of health that directly impact older adults' physical and mental health. These services are a critical part of addressing mental and physical health in the aging population. A home-visiting case manager can observe and address safety risks ranging from something as simple as a loose throw rug that poses a slipping hazard, to more complex issues such as food insecurity and hoarding. Person-centered care planning and a home visiting approach is vital to support older adults to address these risks over time. Many A&A clients show symptoms of depression that are compounded by unresolved barriers including housing, food, transportation, and others. In Sonoma County, existing service delivery models for older adults require that clients be at least aged 60, and for many services (including the existing Collaborative Care Model) the minimum age is 65.

The County of Sonoma also provides proportionately fewer mental health services to Hispanic/Latino and Spanish-speaking clients than to Caucasian and English-speaking clients. The recent Sonoma County Mental Health Service Act, 2019 Capacity Assessment Report states that culturally responsive behavioral health services offered for the Hispanic/Latino population is limited. Overall, this population represents 42% of the Medi-Cal enrollment and yet only represents 13% of the adult consumers in the behavioral health system. Based on local data, the Capacity Assessment continues to assert that language accessibility, citizenship status, lack of culturally competent and bi-lingual staffing all contribute to older adult Latinx populations being deterred from accessing services. However, in fiscal year, 2018-2019 a higher proportion of Hispanic/Latino consumers were admitted to the CSU (Crisis Stabilization Unit). This indicates that Hispanic/Latinx people are being seen only when they reach a crisis phase. Nationally, Hispanic/Latino individuals face cultural barriers to care and health systems with differing levels of cultural competency in late-life depression care.[24] A 2019 report on immigrant disparities in mental health care documents the critical role socio-economic and community-based supports play in reducing these service limitations. They call out the lack of formal and consistent referral pathways and specifically recommend agreements between community-based organizations (CBOs) and safety-net organizations like health centers to improve mental health care.[25]

The previously cited PubMed literature review on suicide risk in older adults emphasized in its conclusions:

> "...the need to integrate specific stress factors, such as feelings of social disconnectedness, neurocognitive impairment or decision making, as well as chronic physical illnesses and disability in suicide models and in suicide prevention programs in older adults. Furthermore, the chronic care model should be adapted for the treatment of older people with long-term conditions in order to improve the treatment of depressive disorders and the prevention of suicidal thoughts and acts."

2.B) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Clearly, to be effective, the provision of mental health services for older adults requires a holistic approach that cannot rely on a single program or agency working alone and instead must leverage inter- and intra-organizational strengths for collective impact. As a CBO serving over 120,000 clients in Sonoma County

[23] HRSA. HPSA Finder. https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx

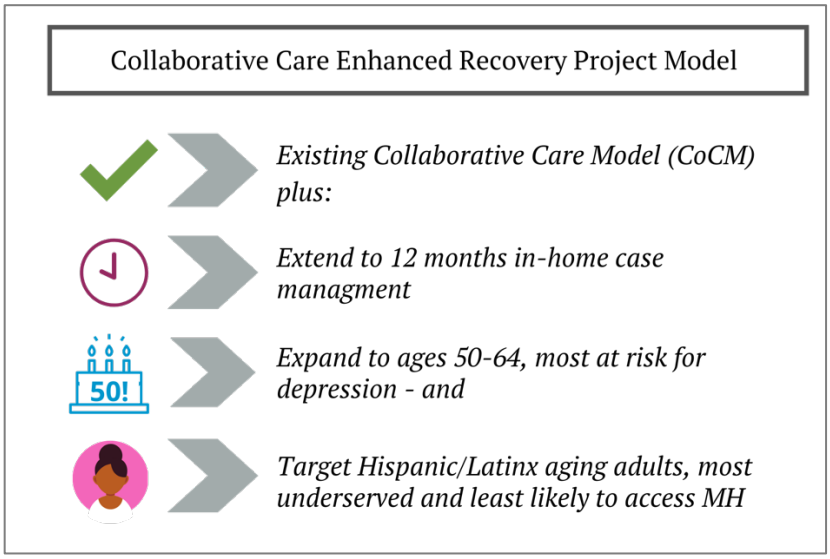
[24] Hoeft, T; Hinton, L; Liu, J; Unutzer, J. "Directions for effectiveness research to improve health services for late-life depression in the United States." American Journal of Geriatric Psychiatry. 2016 Jan; 24(1): 18-30

[25] California Pan-Ethnic Health Network. Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. 2019

annually, Adult & Aging specializes in community-based care, collaborating with internal and external partners to offer a comprehensive network of community resources and referrals. As the largest Federally Qualified Health Center (FQHC) in Sonoma County delivering medical, dental and mental health care to over 42,000 individuals, Santa Rosa Community Health (SRCH) specializes in a whole-person primary care model, with expertise in culturally responsive and trauma-informed diagnosis and treatment. Together, A&A and SRCH are uniquely positioned to develop and test such an intervention for older adults in Santa Rosa, including those who are Hispanic/Latino.

Adult & Aging has identified four areas in which services are not responding to community need: 1) among adults aged 50 to 64; 2) among Hispanic/Latino older adults; 3) in access to home-based coordination of care; and 4) in collaboration across programs and agencies. In response to these four areas and the clearly established need, the County of Sonoma Human Services Department (HSD) Adult and Aging Division (A&A) and Santa Rosa Community Health (SRCH) propose a pilot project to improve treatment for older adults struggling with depression. The *Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services (CCERP)* will augment an established short-term intervention model with longer-term, in-home case management, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression. CCERP will utilize a comprehensive Collaborative Care Model (CoCM) and lengthen the duration of established older adult depression interventions while also expanding the project's focus to increase access to services for two underserved populations as follows:

1. Expand the existing target age group from 65 and older to include ages 50-64;
2. Increase access to depression services for Hispanic/Latino older adults through a focus on providing culturally and linguistically appropriate services and outreach.



The development of this program model was based on several factors. First, A&A has observed service limitations in programs currently available. Existing service delivery models for older adults, in Sonoma County as well as throughout the state, require that clients be at least aged 60, and for many services (including the existing Collaborative Care Model) the minimum age is 65. This leaves adults ages 50-64 underserved, despite this age group being at greatest risk for suicide.[26]

Second, A&A and SRCH are prioritizing linguistically and culturally appropriate services for Hispanic and Latino adults because this group comprises a significant portion of Sonoma County's population, specifically 64% of SRCH's patients. They are less likely to utilize mental health services due to prevalent cultural stigma

[26] American Foundation for Suicide Prevention, 2019. https://afsp.org/about-suicide/suicide-statistics

around mental illness and a shortage of Spanish-language materials and culturally responsive services.[27] [28] Mental health care delivered in the primary care environment, however, is less stigmatizing and easier to access when it is co-located with health care. This is especially important for low-income and Hispanic/Latinx people, for whom there is a high drop-off rate when they are referred to external mental health care, and for treating chronic disease which is closely correlated to depression. Integrated, non-pathologizing care – both from a trusted primary care doctor and, by extension, the trusted in-home case manager, is more effective. Lastly, as noted above, the Hispanic/Latinx population also have a higher prevalence of chronic disease, which correlates to higher rates of depression. There is evidence, however, that using collaborative depression care within a diabetes disease management program is a scalable approach that improves both depression outcomes and patient care satisfaction among Latino patients with diabetes in safety-net clinics.[29] CCERP's proposal to extend the existing CoCM model to twelve months will provide the time needed to build the personal relationships that are central to caring for people who are Hispanic/Latinx, prevent relapses, and maintain health and behavior improvements.

To identify the priority issues to be addressed through CCERP, A&A and SRCH also solicited confidential input from social worker stakeholders and consumers, particularly Hispanic/Latino individuals, who reported cultural and language barriers both to identifying a need for and accessing mental health services. Consumer and service provider stakeholders reported the need for stronger outreach to Hispanic populations (many of whom have linguistic barriers), improved communication across service providers, and in-home support for related issues such as finances, housing, and transportation.

Social workers and clients of A&A's In-Home Supportive Services (IHSS) Program, a program which provides in-home care to older and disabled adults, identified a need for expanding existing mental health services to include ongoing in-home case management and culturally appropriate outreach, specifically through informal resources, and were optimistic about the potential for success. IHSS clients shared that CCERP "…could probably reach a window of people who wouldn't normally reach out for help" and would be "…beneficial to help not just people's mental health but also other problems like finances and housing."

Using the same set of interview questions, SRCH conducted key informant interviews with its staff and patients. Patients interviewed reported that the period after the symptoms have been reduced is a crucial time to establish long-term connections that will contribute to a high quality of life. The results indicated a pressing need for extended care and support such as accessing infrastructure (including medical and public transportation) and reconnecting with their social networks after the critical symptoms of depression have been alleviated.

Both consumer and service provider stakeholders reported the need for stronger outreach to Hispanic/Latino populations, improved communication across service providers, and in-home support for related issues such as finances, housing, and transportation. For example, although Sonoma County residents have access to the North Bay Suicide Prevention hotline, there is a need for expanded mental health supports, particularly for older adults, to reduce the likelihood of a mental health crisis. During post-wildfire mental-health mapping sessions hosted by the Red Cross and the Wildfire Mental Health Collaborative, professionals from NAMI, CA HOPE and other CBOs concurred that there is still significant stigma around "mental health" and how important it was (and is) to adapt the language and approach to remove that barrier to effectively engage people in the care and support they need.

Based on the budgeted case-load, A&A and SRCH anticipate that a minimum of 225 clients could be served during the three-year program: 50 clients in Year 1, 75 in Year 2, and 100 in Year 3 by a care manager[30]

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[27] Hoeft, T; Hinton, L; Liu, J; Unutzer, J. "Directions for effectiveness research to improve health services for late-life depression in the United States." American Journal of Geriatric Psychiatry. 2016 Jan; 24(1): 18-30

[28] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

[29] Wu B, Jin H, Vidyanti I, Lee P, Ell K, Wu S. Collaborative Depression Care Among Latino Patients in Diabetes Disease Management, Los Angeles, 2011–2013. Prev Chronic Dis 2014;11:140081.

[30] The terms case manager and care manager (and case management/care management) are used interchangeably in Sections 2-4 of this document. The Collaborative Care Model uses the term care manager, whereas the more general term for this role, and the term used in most of the citations, is *case manager*.

using a person-centered and culturally responsive approach. Once the program is established and tested, A&A and SRCH fully anticipates both a need and desire to expand the program to other SRCH campuses in Sonoma County based on patient demographics and the established unmet need for mental/behavioral health services.

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

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

The *Collaborative Care Enhanced Recovery Project: Advancing Older Adult Depression Care through Extended Supportive Services* (CCERP) will augment an established short-term intervention, the Collaborative Care Model (CoCM), with longer-term, in-home case management, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression. As a community-based organization (CBO), A&A specializes in collaborating with internal and external partners to deliver community-based care and offer a comprehensive network of community resources and referrals. As a Joint Commission and Patient Centered Medical Home accredited health care provider, Santa Rosa Community Health (SRCH) specializes in integrated primary medical and mental health care that diagnoses and treats the whole person. The integration of community-based social workers trained to work with older adults in the primary care setting and working collaboratively with the patients for a 1-year period is intended to impact the patient's depression symptoms as well as address longer term social determinants of health.

CoCM is an evidence-based approach for integrating physical and behavioral health services. The model includes: brief care coordination (12 weeks); regular monitoring and treatment using validated clinical rating scales; and regular, systematic psychiatric caseload reviews and consultations for clients who do not show clinical improvement. More than 70 randomized controlled trials conducted across diverse practice settings and client populations have demonstrated that collaborative care is more effective and cost-effective than non-integrative care in the treatment of depression, as evidenced by close tracking of depression symptoms using validated rating scales (such as the PHQ-9). The inclusion of a psychiatric consultant in this model gives the primary care provider the ability to utilize psychiatric input when adjusting treatment. Although clients can be referred to mental health specialty care if they don't respond to treatment or request a referral, in practice only a small fraction seek or require referrals to specialty care.[31]

The integrative nature of collaborative care creates new lines of communication and multi-disciplinary channels for information-sharing between the primary care team and other care providers and consultants. A study on clinical inertia in depression treatment shows that this enhanced communication within physician/non-physician teams, paired with psychiatrist consultations, may improve appropriate antidepressant adjustments.[32] Patient outcomes indicated that this systematic approach "can overcome the clinical inertia at is often responsible for ineffective treatments of common mental disorders in primary care.[33] [34]

[31] Unützer, J., Henry Harbin, H., Schoenbaum, M., and Druss, B. (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.

[32] Henke RM, Zaslavsky AM, McGuire TG, Ayanian JZ, Rubenstein LV. "Clinical Inertia in Depression Treatment." Medical Care. September 2009;47(9):959-96

[33] Unützer, J., Henry Harbin, H., Schoenbaum, M., and Druss, B. (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes

[34] Henke RM, Zaslavsky AM, McGuire TG, Ayanian JZ, Rubenstein LV. "Clinical Inertia in Depression Treatment." Medical Care. September 2009;47(9):959-96

Additionally, follow-up care with care managers increases the frequency of contact with clients, thereby enhancing the ability to monitor and detect changes in severity of depression symptoms, which can improve rates of appropriate depression adjustment.[35] Although depression treatment guidelines recommend that clients be seen every one to two weeks during the acute treatment phase, this target is rarely met in clinical treatment models.[36] [37] By supplementing office visits with care management home visits and follow-up, the collaborative treatment model can meet this target guideline for best practice during the acute treatment phase.

The home-visiting care manager delivers the evidence-based intervention Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors).[38] Program components include screening for symptoms of depression; the care manager measures depression through completion of a PHQ-9 (Patient Health Questionnaire depression screening) at regular intervals. The Healthy IDEAS model also includes providing depression education to older adults and their primary caregivers, referrals to social services and resources, and follow-up with primary care and mental health service providers.

Additionally, the care manager provides an in-home assessment of health and social needs, including evaluation of physical health, living conditions, support network, cognition, transportation, home safety, unmet care needs, financial needs, nutritional status, and life-planning. In collaboration with the client, the care manager creates a person-centered care plan that establishes the individual's needs and goals for case management. The care plan can include referrals to community-based organizations for resources such as mental health services, legal assistance, landlord/tenant relations, nutritional services, financial, homecare, transportation, and socialization. Using a brokerage model, the care manager acts as a coach, supporting the client to access and engage in community resources while developing problem-solving skills.

A home-visiting case manager can observe and address safety risks ranging from something as simple as a loose throw rug that poses a slipping hazard, to more complex issues such as food insecurity and hoarding. Person-centered care planning and a home-visiting approach is essential to support older adults to address these risks over time. CoCM essentially gives the primary care provider "eyes in the home," allowing the patient's medical care to be informed and improved by observations that could only occur in the home. To be effective long-term, the provision of mental health services for older adults requires a holistic approach that leverages strengths for collective impact and does not rely on a single program working alone.

Through CCERP, A&A and Santa Rosa Community Health (SRCH) will partner to expand the existing Collaborative Care Model (CoCM) with the addition of long-term home-based case management services. The full intervention will consist of the 12-week (3 months) CoCM intervention and 9 additional months of home-based case management services for a total of 1 year (12 months) of intervention for each patient. Due to the short duration of CoCM's existing 12-week intervention, the supportive services end just as clients are starting to feel better. By extending the length of the intervention to a full year, CCERP's objective is to support clients in maintaining improved depression symptoms and behavioral changes through ongoing case management and support. One study concluded that case management in combination with other depression interventions improves outcomes for both depression and social problems, and that case management may also improve access to health care and reduce hardship by connecting clients with other needed services.[39] Another study showed positive results for practices such as case management, including a drop of 56% in average monthly expenditures on participants after program participation, much of which came from lower inpatient hospital spending.[40]

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[35] Ibid

[36] Ibid

[37] National Committee for Quality Assurance. The State of Health Care Quality 2006. Washington, DC: National Committee for Quality Assurance; 2006. Antidepressant Medication Management; pp. 19–20.

[38] For more information, see http://healthyideasprograms.org/

[39] Areán, P.; Mackin, S.; Vargas-Dwyer, E.; Raue, P.; Sirey, J.; Kanellopoulos, D.; Alexopoulos, G. "Treating Depression in Disabled, Low-income Elderly: A Conceptual Model and Recommendations for Care." International Journal of Geriatric Psychiatry. 2010 Aug; 25(8): 765–769

[40] County Medical Services Provider (2013). Local Health Connections Pilot: Findings and Lessons Learned

To help facilitate clients transitioning out of the case management program and into independent care maintenance, A&A and SRCH will take a phased approach to case management for CCERP clients, gradually decreasing the frequency and level of case management support over the course of the nine-month period. Phasing case management services according to client's individual needs will enable project staff to connect clients with necessary supports and resources as they move toward stability before gradually transferring care. Staff will use practices to mobilize community support for vulnerable older adults during the period of transition out of CCERP, facilitating continuity of care through enduring ties to the community and support systems.

A&A and SRCH will launch services at SRCH's Lombardi Campus. The Lombardi Campus offers comprehensive primary care, integrated mental health care, women's health, specialty care, and also has an onsite pharmacy and lab. It opened in 1996 and is located adjacent to the Roseland neighborhood that has a population of 43% Hispanic/Latino people. As such, the Lombardi Campus has the highest concentration of SRCH's Hispanic/Latinx clients, up to 80% of whom are best served in Spanish. The longer-term goal is to expand the model to three other large SRCH campuses, making this innovative approach to depression care available to the majority of low-income older adult clients of in metropolitan Santa Rosa.

Care management meetings will be held at SRCH and attended by all CCERP staff. As clients demonstrate fewer depression symptoms over the nine-month case management period, their cases will be brought back to the multidisciplinary team for brief monthly or biweekly check-ins.

CCERP will be implemented by a designated project team as follows:

- 1.0 FTE CBO Care Manager (embedded at SRCH)
- 0.5 FTE CBO Program Planning and Evaluation Analyst (PPEA)
- 0.1 FTE CBO Supervisor
- 0.275 SRCH Program Administrator
- 0.5 SRCH Care Coordinator/Patient Navigator
- 0.1 SRCH Primary Care Physician
- 0.013 FTE SRCH Psychiatric Consultant
- 0.1 FTE SRCH RN Case Manager
- 0.1 FTE SRCH Behavioral Health Manager Supervision
- 0.2 FTE SRCH Behavioral Health Provider

CCERP will ensure that A&A and SRCH's innovative recovery model provides Hispanic and Latino older adults with services that are both culturally responsive and linguistically appropriate. To that end, A&A will require that Social Workers who serve as project staff are bilingual in Spanish, and SRCH will have strong bilingual representation in all project-related positions. CCERP will ensure that all community outreach and education, including printed materials, are provided in both culturally appropriate English and Spanish.

Further, SRCH has extensive experience working with the Hispanic and Latino community, and almost all providers and all team staff are bilingual and/or bicultural. This is highly unique and valuable as there is a recognized shortage of bilingual and bicultural medical and mental health providers locally and nationally. All SRCH providers are trained to see mental health as a part of overall health and to offer services in a non-stigmatizing fashion in the context of primary care. SRCH care teams also recognize the necessity of and prioritize building up the personal relationships and trust that are central to delivering sensitive and effective health care for the Hispanic/Latino community. Receiving care in a trusted setting from a bilingual and/or bicultural provider also enables conversations that can address the traditional stigma around mental health in the Latino culture. With trust and time, clients can become more receptive to receiving services and pursuing different treatment options, such as medication for depression. SRCH has also established relationships with Hispanic and Latino-serving partners such as Latino Service Providers, La Plaza, California Human Development Corporation, Community Action Partnership of Sonoma, Binational Health Fairs, Center for Well-Being, and others, and will leverage these to expand outreach and ensure that CCERP delivers culturally appropriate services.

A&A is committed to ensuring continuity of care for CCERP clients and will continue to actively work on identifying ways to make the proposed project sustainable beyond the duration of the project period. Following the end of MHSA Innovation funding, clients will continue to have access to the programs of the Sonoma County Behavioral Health Division and available SRCH services. To help facilitate clients transitioning out of the case management program and into independent care maintenance, A&A and SRCH will take a phased approach to case management for CCERP clients, gradually decreasing the frequency and level of case management support over the course of the nine-month period. Adjusting case management services according to individual needs will enable project staff to connect clients with the necessary resources to support their recovery as they move toward stability before a gradual transfer of care. Staff will use practices to mobilize community support for vulnerable older adults during the period of transition out of CCERP, facilitating continuity of care through enduring ties to the community and support systems.

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

Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

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

The Collaborative Care Model (CoCM) is an evidence-based approach for integrating physical and behavioral health services, which in its existing form has been successfully implemented by A&A in partnership with local clinics to serve Sonoma County's older adults with depression. Bringing together the clinical expertise of Santa Rosa Community Health (SRCH) and the social services expertise of community-based senior services of Sonoma County Adult & Aging (A&A), this intervention improves access to effective depression treatment in primary care for older low-income adults.

Since 2015, A&A has partnered with Petaluma Health Center (PHC) in the implementation of a CoCM program for late-life depression, with A&A serving in the role of the community-based organization (CBO). To date, A&A has acted as the backbone agency and project manager to implement CoCM with adults 65 years and older in three Federally Qualified Health Centers (FQHCs) in the county.

In this model, A&A care managers are co-located at the health center, with responsibility for home visits and care coordination at the clinic. The home-visiting care manager is an integral part of the care team, which also includes a primary care provider, RN care manager, and psychiatric consultant. Through the CoCM approach, A&A care managers provide person-centered assistance, addressing depression symptoms and social needs by empowering individuals to access the resources needed to remain safely at home, with a focus on improving health and safety, reducing depression, and developing social and community connections.

Looking specifically at the effectiveness of the CoCM model for low-income Spanish-speaking Hispanic/Latinx people, a 2012 study showed that Spanish-speaking Hispanic clients had significantly greater odds of achieving a clinically meaningful improvement in depression at the 3-month follow-up compared to non-Hispanic whites, even accounting for age. The study further concluded that results suggest "a strong opportunity to improve mental health care for non-English-speaking Hispanic adults in the US.[41]

Although the existing CoCM model has been demonstrated as effective in improving depression symptoms as measured by the PHQ-9 depression screening, including with a low-income and Spanish-speaking population, the modifications proposed through CCERP have the potential to improve upon this model by addressing identified limitations in services. Through serving thousands of older adults over ten years of

[41] Sanchez, Katherine and Terling Watt, Toni. 2012. Collaborative Care for the Treatment of Depression in Primary Care with a Low-Income, Spanish-Speaking Population: Outcomes from a Community Based Program Evaluation. The University of Texas at Arlington School of Social Work.

MHSA-funded work, A&A has observed four areas in which there are opportunities to strengthen services: 1) among adults aged 50 to 64; 2) among Hispanic and Latino aging adults; 3) in access to extended home-based case management and follow-up; and 4) in collaboration across programs, especially medical and community-based services. This CCERP project seeks to address the aforementioned challenges.

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

Based on the number of individuals served in Adult & Aging (A&A)'s existing CoCM programs, and A&A's experience with community-based care coordination, it is anticipated that CCERP will have the capacity to serve a minimum of 225 clients with care management services during the three-year project: 50 clients in Year 1; 75 clients in Year 2, and 100 clients in Year 3. Year 1 will be a ramp-up period focused on training, hiring, developing workflows, and establishing evaluation structures, and thus will serve fewer clients. In Years 2 and 3, the program will have the capacity to serve more individuals.

Based on the experience of A&A and Petaluma Health Center (PHC), maximum caseloads for a half-time care manager are approximately 25 to 30 clients per caseload, a benchmark which is supported by the findings of a Cost Study conducted on the PHC & A&A CoCM project in April 2019, which indicated the program served 28 unique clients during a 4-week period.[42] These findings pertain to the 12-week CoCM intervention model as utilized by a half-time (0.5 FTE) care manager, and in the 4th year of a well-established program. Since CCERP will employ a full-time care manager (1.0 FTE), the caseload capacity for the established intervention model would translate to an estimated 50-60 clients, except that CCERP will also utilize a phased case management approach which will substantially increase caseload capacity.

With CCERP's phased case management approach, clients will remain active for a more sustained period of 12 months, but with a decreased level of intervention as they build a network of supportive resources and move towards transfer of care. This graduated level of care over time will allow for a larger capacity caseload, since clients in later phases (i.e. in the latter half of the 12-month period) will require less time than newer clients. Due to these variations in levels of care, combined with the utilization of a full-time care manager, CCERP will have a caseload capacity that is substantially higher than the existing CoCM program.

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

The target population is low-income clients at SRCH's Lombardi Campus who are 50 and over with a focus on inclusion of Hispanic/Latino Spanish-speaking clients through targeted in-reach and linguistically/culturally appropriate care. SRCH currently serves over 42,000 culturally diverse and low-income people living in the greater Santa Rosa area every year.[43] SRCH clients struggle with numerous socioeconomic and cultural barriers to health including poverty, language, literacy, food insecurity, addiction, and homelessness. More than 97% of SRCH clients live below 200% of the federal poverty level. Almost one-quarter are over the age of 50 and two-thirds of these are ages 50 to 64, the age range that CCERP will add to CoCM. 60% of SRCH clients are Hispanic and 38% are best served in a language other than English.

At the SRCH Lombardi Campus, where CCERP will launch, the concentration of Hispanic and Latino clients is especially high. 80% of Lombardi clients either prefer to receive care in Spanish or are monolingual Spanish. Across the agency, over 4,500 clients are diagnosed with depression. 25% of the 1,718 clients with mental health visits in the last 12 months at the Lombardi Campus were over age 50 (430), close to half of whom (46%) are identified in the electronic health record (EHR) as Hispanic (210). The Lombardi Campus only has a 64% compliance rate for a documented follow-up plan following a positive screen for depression (PHQ2). This reflects a 17% drop from a high of 80% in 2017, much of which is due to the bottom-line demands of SRCH's fire-recovery combined with the shortage of mental health support across the county.

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[42] University of Washington AIMS Center, 2019. Report on Cost of Care for Collaborative Care Innovation at Sonoma County Human Services Dept, Adult & Aging Division and Petaluma Health Center

[43] Santa Rosa Community Health, 2019

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

Through CCERP, A&A will expand the existing CoCM to serve a more diverse group for a longer period of time through the following modifications:

1. Extending the period of in-home care management services from 12 weeks to 12 months in order to: (1) ensure social determinants of health are addressed over a one-year period; and (2) allow the primary care team to align the community care plan goals with the medical and behavioral health goals established in the clinic setting;
2. Expanding the program population to include adults aged 50 to 64 (in addition to 65+) who have two or more activities of daily living (Katz Scale) or instrumental activities of daily living (Lawton scale) impairments;
3. Increasing targeted outreach to and engagement of Hispanic and Latino Spanish-speaking individuals, with an enhanced focus on culturally and linguistically appropriate care.

In addition, the existing service (CoCM) that is evidence-based is a 12-week intervention that begins to address identified depression in older adults yet has limiting factors in that the brief intervention does not allow for more comprehensive home-based assessment and follow-up support to address barriers to wellness. The additional 9-months of home-based care management will provide the continuity for the client and at the minimum support sustained outcomes, if not improve both physical and mental health outcomes.

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

The closest models that currently exist are those currently being implemented in California through a grant from the Archstone Foundation. These models are overseen by the University of Washington (also funded by the Archstone Foundation). There are currently two Collaborative Care models being implemented in Sonoma County (one at Petaluma Health Center/Rohnert Park Health Center and one at West County Health Centers). These models are short-term (12 weeks) and only focused on clients that are 65 years and older. Literature reviews do not reveal any other similar models whereby primary care clinics are partnering with community-based organizations to focus on depression in older adults (or depression in clients 50 years and older).

Based on a review of existing literature and information collected through key informant interviews, the expanded scope of CCERP's programming and target population is both novel and needed. Although case management in combination with other depression interventions has been shown to improve outcomes,[44] we could not find documentation of the CoCM depression intervention model being applied in combination with long-term case management nor to the age group 50-64. Additionally, the need for culturally and linguistically appropriate depression care for Hispanic, Latino and immigrant adults is also well-documented both nationally[45] [46] and locally.[47]

University of Washington AIMS Center (Advancing Integrated Mental Health Solutions), that oversees California's CoCM depression programs for older adults and is at the forefront of late-life depression research, has verified the absence of CoCM depression care programs that include these new, expanded applications. The limitations of current programs' capacity to meet the needs of Sonoma County's aging

[44] Areán, P.; Mackin, S.; Vargas-Dwyer, E.; Raue, P.; Sirey, J.; Kanellopoulos, D.; Alexopoulos, G. "Treating Depression in Disabled, Low-income Elderly: A Conceptual Model and Recommendations for Care." International Journal of Geriatric Psychiatry. 2010 Aug; 25(8): 765–769.

[45] National Alliance on Mental Illness, https://www.nami.org/find-support/diverse-communities/latino-mental-health

[46] California Pan-Ethnic Health Network. Accessing Mental Health in the Shadows: How Immigrants in California Struggle to Get Needed Care. 2019

[47] Santa Rosa Community Health, 2019

population is also demonstrated by A&A's long waiting lists for existing home-based care coordination programs,[48] which are a vital way to address the risks and social determinants of health that directly impact older adults' physical and mental health.

LEARNING GOALS/PROJECT AIMS The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.
A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?
B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

A&A and SRCH will take a three-pronged approach to evaluating the success of CCERP's innovation in meeting the primary purposes described above. Through the following learning goals and related questions, A&A and SRCH will measure the success of the CCERP innovations with the goal of demonstrating a new precedent for expansion of effective practices in the mental health system.

Learning Goal/Project Aim #1: To assess the project's population impact via sustained patient outcomes by establishing whether extending the duration of home-based care management from 12 weeks to 12 months results in sustained improvement of depression symptoms over the course of the intervention period. CCERP will contribute to the expansion of effective practices in the mental health system by demonstrating whether an extended period of case management is an effective method of improving long-term outcomes for older adult depression CoCM interventions. By adding this new element to an evidence-based practice, CCERP can also set a precedent for a more comprehensive Collaborative Care Model that provides not only an extended period of case management, but also lengthens the duration of collaborative care's integration of both the medical model and the recovery model in optimizing patient care.

Question: For adults 50 and older whose depression symptoms improve with the existing CoCM's 12-week intervention, are these improvements sustained over the course of an additional 9-month case management period?

Learning Goal/Project Aim #2: To assess the project's system impact via appropriate health care utilization, as indicators that clients are accessing optimal medical care that is preventative in nature and supports their overall physical and mental health. CCERP will contribute to the expansion of effective practices in the mental health field by demonstrating how (or whether) combining an established CoCM depression intervention with long-term case management, while also extending the period of collaboration between the medical model and recovery model, can support older adults' in their appropriate utilization of health care. This new approach can also further the understanding of how collaborative teams that integrate medical care with mental health care can lead to improved patient outcomes that in turn have a positive impact on the health care system via more appropriate utilization of care and resources.

Question: For adults age 50 and older who receive a 12-week CoCM depression intervention plus nine months of case management, is there an improvement in appropriate utilization of preventative health care, as compared to participants' health care utilization prior to the intervention (baseline) and over the course of the treatment intervention?

Learning Goal/Project Aim #3: To assess the effectiveness of this intervention for the Hispanic and Latino population. Santa Rosa Community Health serves a large population of Hispanic and Latino adults. The goal of serving this population is to address the cultural barriers to serving Hispanic and Latino adults with symptoms of depression. CCERP will accomplish this goal by leveraging SRCH's deep expertise working with and for the Hispanic and Latino community, and their relationships with Hispanic and Latino-serving partners, to inform program development and ensure that culturally/ linguistically appropriate services and materials are provided.

[48] Sonoma County Human Services, Adult & Aging Division, 2019

Question: For Hispanic and Latino adults age 50 and older who receive the CCERP intervention, are there sustained depression symptom improvements and improvements in appropriate health care utilization? Pre and post PHQ-9 scores will be used in addition to metrics to be determined e.g., pre- and post-surveys on patient perception of mental health services.

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

Learning Goal/Project Aim #1: To assess the project's population impact via sustained patient outcomes, with the goal of establishing that lengthening the duration of home-based case management from 12-weeks to 12-months results in sustained improvement of depression symptoms over the course of the intervention period.

Indicator(s): PHQ-9 scores will be used to measure the rate of response and remission maintained over the full-service period, by administering the PHQ-9 at regular intervals throughout the 12-month period. The post scores will also be compared to pre-scores taken at both at intake (baseline) and at the 12-week mark.

Learning Goal #2: To assess the project's system impact via appropriate utilization of preventative health care as an indicator that clients are receiving optimal medical care that is preventative in nature and supporting their overall physical and mental well-being.

Indicator(s): CCERP staff will measure appropriate utilization by metrics to be determined during the planning period. Indicators of appropriate health care utilization include: fewer urgent medical visits, decreased ER visits, increase in preventative primary care visits, tie to A1c/Hypertension (HTN)/cancer screenings, and medication adherence.

Learning Goal #3: To assess the effectiveness of this intervention for the Hispanic and Latino population.

Indicator(s): PHQ-9 scores will be used to measure the rate of response and remission maintained over the full-service period, by administering the PHQ-9 at regular intervals throughout the 12-month period. The post scores will also be compared to pre-scores taken both at intake (baseline) and at the 12-week mark. In addition, CCERP staff will measure appropriate utilization by metrics to be determined during the planning period. Indicators of appropriate health care utilization include: fewer urgent medical visits, decreased ER visits, increase in preventative primary care visits, tie to A1c/HTN/cancer screenings, and medication adherence.

Learning and Evaluation Approach:

- The CBO Program Planning and Evaluation Analyst (1.0 FTE CBO Care Manager (embedded at SRCH)
- 0.5 FTE CBO Program Planning and Evaluation Analyst (PPEA)
- 0.1 FTE CBO Supervisor
- 0.275 SRCH Program Administrator
- 0.5 SRCH Care Coordinator/Patient Navigator
- 0.1 SRCH Primary Care Physician
- 0.013 FTE SRCH Psychiatric Consultant
- 0.1 FTE SRCH RN Case Manager
- 0.1 FTE SRCH Behavioral Health Manager Supervision
- 0.2 FTE SRCH Behavioral Health Provider

) will partner with the SRCH Program Administrator and additional A&A and SRCH staff to evaluate the project. Based on stakeholder and staff input obtained during proposal development, the evaluation will draw upon existing data and evaluation infrastructure both at A&A and at SRCH to measure the learning goals. A&A currently acts as the administrative backbone for the existing CoCM projects at other locations, (Petaluma Health Center and West County Health Centers), as well as for other depression intervention programs that utilize PHQ-9 scores to measure and track depression symptoms, including the MHSA-funded (Prevention & Early Intervention) Older Adult Collaborative (OAC) project. The OAC project will be leveraged

by CCERP as this project provides solely community-based case management (no primary care involvement) using the Healthy IDEAS intervention. As a result, CCERP clients may be referred to OAC partners if they have on-going case management needs after the 1-year CCERP intervention. The evaluation tracking systems developed for the data collection and reporting of these existing projects can inform the structure for the evaluation of CCERP and will be adapted to align with CCERP project goals.

The A&A Care Manager will record PHQ-9 scores and other applicable care management documentation in SRCH's Electronic Health Record (EHR), so that the care manager's documentation is integrated with that of the care team at SRCH. The A&A PPEA will work with the SRCH Program Administrator to coordinate the collection and integration of de-identified data from both organizations into a format that meets program requirements and tracks performance measurements.

A&A and SRCH will evaluate client focused outcomes through PHQ-9 scores and additional metrics that can serve as a proxy for appropriate utilization, including self-reports, data points in electronic medical health records, hospitalization, and emergency room visits. The Sonoma County Human Services Department's Planning, Research, and Evaluation Team (PREE) will support clinical staff to measure these outcomes. A&A and SRCH will additionally evaluate the success of the program purpose of increasing access for unserved or underserved groups, by assessing whether the percentage of Spanish-speaking adults enrolled in CCERP is statistically similar to the total percentage of Spanish-speaking SRCH clients age 50 and older. System-wide outcomes will be evaluated through metrics to be developed during the planning period.

The CBO PPEA, with support from the HSD Planning, Research, and Evaluation Team and additional A&A and SRCH staff as needed, will work to track health care utilization data from SRCH and, as available, through the County and/or Partnership Health Plan to analyze the utilization of care in the county's medical and mental health service delivery system.

SRCH's Quality and Data team will support the CBO PPEA and SRCH Program Administrator in data collection, analysis, reporting, and dissemination. SRCH data staff will utilize the Relevant analytics tool to collect and analyze actionable data. This tool provides standard reports for depression screening and follow-ups, and a full array of medical data, and the capability to develop additional reports to support CCERP goals.

Evaluation Measures and Methods

SRCH has a comprehensive electronic health record (EHR) that is used by the integrated care team to capture all patient information, health issues, and visit history. SRCH also uses a very robust data-analytics and visualization platform to mine, analyze and share that data to manage population health at the patient, provider, care team, clinic, and health condition level. All information for CCERP will be kept in and drawn from the EHR. This includes demographics, chronic disease diagnoses, visit histories, screening scores, etc. Reports that target the project population will be developed over the course of the project to track evaluation measures and enable continuous monitoring and quality improvement.

Upon project initiation, the CCERP team will convene to finalize the specific set of measures to track, establish the required workflows for gathering, sharing, and analyzing data, and establish baselines for all measures. Data will be analyzed first for improvement with the program cohort and then compared against baseline of the target population not participating in the intervention. Any screens or tools will also be checked for cultural and linguistic appropriateness and effectiveness for Hispanic/Latino and Spanish-speaking clients. Given the stated learning goals/project aims, measures and methods will likely include such items as:

- **Response and remission rates for depression:** Collect participant PHQ-9 scores at induction, three-, six-, nine-, and twelve-month marks in the program. Compare to depression response rates for the established 12-week CoCM program, and to individual baselines for each participant.
- **Program adoption and adherence rates**: Track the number of potential program participants, how many accept the program, # of visits and calls completed, and how long they stay in the program. Compare to rates for the established CoCM program.

- **Positive health care utilization behaviors:**
    - # of patient preventative care visits. Monitor follow through or no-show rate for primary care and mental health appointments, i.e. when primary care provider recommends additional visits to check in on physical and mental health issues (depression, diabetes, heart health, etc.). Use EHR data to compare against baseline of depressed clients not participating in program with the goal of increasing program participant follow through in recommended and preventative care.
    - % of clients compliant with recommended health screenings. Track cohort compliance with cancer, HIV/HepC, A1c, etc. Use EHR data to compare against baseline with the goal to increase compliance.
    - Medication adherence. Monitor patient's use of prescribed medication with the goal of increasing adherence by a reasonable percentage, data collected through provider and care manager interactions.
- **Decreases in social isolation:** Results from The Campaign to End Loneliness Measurement Scale, a three-question self-assessment. Capture at induction, three-, six-, nine-, and twelve-month marks in the program with the goal to see an increase in positive indicators such as the quality of relationships.
- **Improvement in social determinants of health:**
    - # and type of Social Determinants of Health (SDOH) in program participants. Compile results from the PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) screening tool and Healthy IDEAS toolkit, gathered in-clinic and at in-home assessments.
    - Progress on the goals each patient establishes as priorities for their improved health and well-being. Definitions for progress will be defined based on the various categories included in the assessments. For example, housing may be an identified priority issue, but complex to solve. Throughout the project, the CCERP team will collate data to identify themes around patient needs and barriers to care.
    - # of referrals made. Use EHR and NorCal Resources database to make, share and track referrals made to connect clients with available resources such as a healthy food box or yoga groups.
- **Improve outcomes and reduce disparities or limitations in care for Hispanic/Latino and Spanish speaking clients age 50 and above with depression**.
    - Of those identified with depression, how do their A1c and hypertension compare to their white cohort at induction and over the program period?
    - Of those identified with depression, how do their SDOH compare to their white cohort at induction and over the program period?
    - How do program adoption and adherence rates vary between Hispanic/Latino and white clients?
    - Is insurance coverage a barrier to program participation or engagement with recommended care for immigrant or undocumented clients? There is a high-percentage of these individuals at the Lombardi Campus. Insurance status can be collected from the EHR to identify care limitations for this population.

SECTION 3: ADDITIONAL INFORMATION FOR REGULATORY REQUIREMENTS

CONTRACTING

Sonoma County Department of Health Services (DHS) will establish an inter-departmental Memorandum of Understanding (MOU) with the Human Services Department, Adult and Aging Division (A&A) to establish goals, scope of work, roles and responsibilities for the proposed three-years of Innovation funding.

The proposed project, Collaborative Care Enhanced Recovery Project (CCERP), will be a collaboration between the Sonoma County Human Services Department/Adult & Aging Division (A&A) and Santa Rosa

Community Health Centers (SRCH), with A&A acting as the administrative backbone of the project. As the administrative lead, A&A will ensure that the project and its execution are in alignment with the Project Plan, including regulatory compliance, structuralization of the evaluation plan, and establishment of contracts. A&A will establish a contract with SRCH that clarifies these same items as well as payment terms, since SRCH's funding will pass through A&A. HSD's dedicated Contracts & Procurement unit will develop the contract with input from A&A and SRCH. The Contracts & Procurement unit will handle all aspects of insurance compliance, risk management, and the signature process. The A&A team also includes a dedicated fiscal team to coordinate and manage revenue, invoicing, and payment.

The MHSA Coordinator of the Sonoma County DHS Behavioral Health Division will be the main point of contact to monitor progress of CCERP and assure contract compliance and MHSA adherence per County and State regulations. The MHSA Coordinator may provide technical support in program delivery and evaluation, fiscal reporting and program reporting for this project. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and Innovation regulations. In addition, A&A 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).

In addition, the A&A PPEA will schedule project planning meetings during the ramp-up period and administrative meetings throughout the contract period, to support and facilitate relationship building, and project fidelity. A&A will also offer technical assistance to SRCH as needed, including connecting SRCH staff with their peers on PHC's CoCM team to leverage PHC's experience regarding best practices, workflow, and other lessons learned. The evaluation will be conducted internally with a team from both HSD and SRCH.

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.

The table below details 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**

Below is a timeline of the activities in the Community Program Planning Process for 2020 and 2021.

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.
Dec	Held public hearing at the Sonoma County Mental Health Board meeting. 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 out to MHSA Steering Committee members, MHSA Stakeholder Committee, contacts on the MHSA Newsletter list with over 2000 contacts, County staff and 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 and **this is detailed on page 6 and inserted below:**

To identify the priority issues to be addressed through CCERP, A&A and SRCH also solicited confidential input from social worker stakeholders and consumers, particularly Hispanic/Latino individuals, who reported cultural and language barriers both to identifying a need for and accessing mental health services. Consumer and service provider stakeholders reported the need for stronger outreach to Hispanic populations (many of whom have linguistic barriers), improved communication across service providers, and in-home support for related issues such as finances, housing, and transportation.

Social workers and clients of A&A's In-Home Supportive Services (IHSS) Program, a program which provides in-home care to older and disabled adults, identified a need for expanding existing mental health services to include ongoing in-home case management and culturally appropriate outreach, specifically through informal resources, and were optimistic about the potential for success. IHSS clients shared that CCERP "…could probably reach a window of people who wouldn't normally reach out for help" and would be "…beneficial to help not just people's mental health but also other problems like finances and housing."

Using the same set of interview questions, SRCH conducted key informant interviews with its staff and patients. Patients interviewed reported that the period after the symptoms have been reduced is a crucial time to establish long-term connections that will contribute to a high quality of life. The results indicated a pressing need for extended care and support such as accessing infrastructure (including medical and public transportation) and reconnecting with their social networks after the critical symptoms of depression have been alleviated.

Both consumer and service provider stakeholders reported the need for stronger outreach to Hispanic/Latino populations, improved communication across service providers, and in-home support for related issues such as finances, housing, and transportation. For example, although Sonoma County residents have access to the North Bay Suicide Prevention hotline, there is a need for expanded mental health supports, particularly for older adults, to reduce the likelihood of a mental health crisis. During post-wildfire mental-health mapping sessions hosted by the Red Cross and the Wildfire Mental Health Collaborative, professionals from NAMI, CA HOPE and other CBOs concurred that there is still significant stigma around "mental health" and how important it was (and is) to adapt the language and approach to remove that barrier to effectively engage people in the care and support they need.

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

A) Community Collaboration – CCERP is a collaboration between a community-based social services agency focused on serving older adults (A&A) and an FQHC primary care clinic (SRCH). The project will also include collaboration with other community-based organizations, especially SRCH's Hispanic and Latino-serving partners, as well as stakeholders and consumers to inform program refinement through surveys and other community engagement opportunities to share progress updates and solicit input from the community.

B) Cultural Competency – CCERP will facilitate improved access to services to two underserved populations: older adults including ages 50-64, and the subset of Hispanic and Latino older adults. The project will leverage existing expertise from both agencies utilizing bilingual/bicultural staff and ensure that the agencies hire and train culturally competent staff to focus on the Hispanic and Latino older adult population experiencing symptoms of depression.

C) Client-Driven – The care management model being employed in CCERP is Healthy IDEAS,[49] a person-centered and client-driven model of care focused on the client's goals for care management. Santa Rosa Community Health is accredited as a designated Patient Centered Medical Home.

D) Family-Driven – Where appropriate and with the consent of the patient, this model will incorporate the client's family into the care management goals.

E) Wellness, Recovery, and Resilience-Focused – CCERP's in-home case management model supports and facilitates wellness, recovery, and resilience by empowering clients to set and reach individual goals while addressing social determinants of health***.*** The collaborative care model also addresses wellness by integrating the patient's medical and mental health care to optimize the patient experience of whole-person care. Extending the duration of the intervention from 12 weeks to 12 months will allow care managers to assist the patient in building the supports and resources necessary to continue pursuing wellness and recovery.

F) Integrated Service Experience for Clients and Families – CCERP brings together a social service provider with a medical provider is a model for an integrated service experience for clients.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

[49] For more information, see http://healthyideasprograms.org/

During the planning phase, A&A and SRCH leadership will convene an Older Adult Steering Committee (Committee) that is comprised of consumers, service providers, project staff and social workers, and adult community members aged 50-64, with a focus on Hispanic and Latino stakeholders. Evaluation of CCERP's success will include stakeholder engagement via the Older Adult Steering Committee. The Committee will meet at predetermined intervals and will serve as an oversight body to track the project's progress towards meeting its learning goals through regular group discussions and project updates. The Committee will provide strategic direction for CCERP, including input on project refinement and a plan for soliciting feedback from the larger community.

SRCH will also leverage their expertise in outreaching Spanish-speaking populations, as well as their relationships with Hispanic and Latino-serving community partners, to ensure that CCERP identifies culturally competent initiatives and pursues the most effective and inclusive communication channels. As the project progresses, A&A and SRCH leadership will determine whether any stakeholder group is not meaningfully involved in the engagement and evaluation process, and will actively reach out to those groups as necessary.

The CBO PPEA and SRCH Program Administrator will be responsible for obtaining end-user feedback. These staff members will leverage existing community groups, including the Area Agency on Aging (AAA), Geriatric Workforce Enhancement Program, Sonoma County Health Action, My Care My Plan, and Redwood Community Health Coalition (RCHC). The CBO PPEA and SRCH Program Administrator will work with these groups, and others, to solicit consumer and other stakeholder feedback that will be shared with the Older Adult Steering Committee.

SRCH has demonstrated dedication to meaningful involvement of stakeholders to ensure culturally appropriate services; SRCH uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to regularly survey clients regarding their satisfaction with services received at SRCH sites. Clients are additionally invited to participate in an annual mail-in survey about their experiences, which may be expanded to include questions about CCERP. SRCH will include questions about the evaluation on its annual survey to be administered to all clients of the proposed project and the staff who serve them.

CCERP will ensure that A&A and SRCH's innovative recovery model provides Hispanic/Latino older adults with services that are both culturally responsive and linguistically appropriate. To that end, A&A will require that Social Workers who serve as project staff are bilingual in Spanish, and SRCH will have strong bilingual representation in all project-related positions. CCERP will ensure that all community outreach and education, including printed materials, are provided in both culturally-appropriate English and Spanish. As well-documented in other sections of this plan, SRCH's experience working with and for the Hispanic and Latino community is extensive, as are their relationships with Hispanic and Latino-serving community partners, both of which will be leveraged to inform and expand outreach and to ensure that CCERP delivers culturally appropriate services.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

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 A&A and SRCH to look holistically at the success of the project. Data driven decision-making will determine if the project is promising and additional time is indicated to further develop definitive results for the project. If necessary, a criterium 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. 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.

A&A is committed to ensuring continuity of care for CCERP clients and will continue to actively work on identifying ways to make the proposed project sustainable beyond the duration of the project period. Following the end of MHSA Innovations funding, clients will continue to have access to the programs of the Sonoma County Behavioral Health Division and available SRCH services. To help facilitate clients transitioning out of the case management program and into independent care maintenance, A&A and SRCH will take a phased approach to case management for CCERP clients, gradually decreasing the frequency and level of support over the course of the nine-month period. Phasing case management services according to client's individual needs will enable project staff to connect clients with necessary supports and resources as they move toward stability before gradually transferring care.

Staff will use practices to mobilize community support for vulnerable older adults during the period of transition out of CCERP, facilitating continuity of care through enduring ties to the community and support systems. After observing the improvements in patient outcomes resulting from the existing CoCM project, PHC has committed to sustaining services beyond the life of the initial grant; similarly, SRCH aims to develop methods to sustain the model beyond the duration of Innovation funding.

To explore options that will support long-term sustainability and ongoing funding, A&A is currently consulting with the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center to incorporate Medicare billing to reimburse partners, including SRCH and PHC, for costs associated with CoCM. It is A&A's goal to identify a process by which to reimburse SRCH for time spent administratively on CCERP and for time spent on the project by multidisciplinary team staff. The primary care physician would bill Medicare monthly when the multidisciplinary care team delivers services that meet or exceed a time threshold defined under the billing code, following which the internist would pay the behavioral health care manager and psychiatric consultant directly. This billing model for CoCM has been implemented successfully in other health care settings nationally, including Rush University Medical Center in Chicago.

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

The Collaborative Care Enhanced Recovery Project (**CCERP)** is aimed at serving adults with mild to moderate depression. At the same time, CCERP will extend its ability to identify the range of mental health issues in the Latino community from mild to moderate to severe, and then connect community members to the most appropriate level of care. CCERP model includes referral to the psychiatrist or higher levels of intervention where higher levels of risk are identified. The great benefit is identifying untreated, undertreated, unidentified issues or those lost to care. If and when people with serious mental illness are identified through CCERP outreach, they will be connected to the appropriate level of care. Both project partners are highly versed in community resources to ensure appropriate and continuous care and SRCH, in particular as an FQHC, would be the primary care home for these clients and follow all the established protocols for clients with severe mental illness.

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

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?

Lessons learned through CCERP will be shared with the community through regular evaluation summaries, developed by A&A and SRCH in accessible language in both English and Spanish with feedback from the Older Adult Steering Committee. The Committee will engage a broad representation of stakeholders, including strong representation from the Hispanic and Latino community and a culturally diverse assembly of staff and consumers, to participate in the planning and execution of communication initiatives to disseminate CCERP results. The Committee's participation will help ensure effective outreach to Spanish-speaking

populations and will support CCERP's ability to clarify key messages and identify initiatives to attract community members' attention.

With support and assistance from HSD's dedicated Communications Manager, A&A will disseminate this summary through established County, agency, and Older Adult Steering Committee public information channels, including social media. Leveraging the channels of CCERP lead agencies, and their partners, will ensure communication with a wide group of stakeholders. A&A and SRCH will disseminate information about CCERP, its evaluation, and lessons learned with similar programs, agencies, and clinics within the county and regionally that would benefit from implementation of the model.

How will program participants or other stakeholders be involved in communication efforts?

The aforementioned Older Adult Steering Committee (Committee) will engage a broad representation of stakeholders, including a culturally diverse assembly of staff and consumers, to participate in the planning and execution of communication initiatives to disseminate CCERP results. The Committee will include strong representation from the Hispanic and Latino community, whose participation will help ensure effective outreach to Spanish-speaking populations and will support CCERP's ability to clarify key messages and identify initiatives to attract community members' attention.

CCERP will leverage relationships and partnerships with existing community groups, including the Area Agency on Aging (AAA), Geriatric Workforce Enhancement Program, Health Action, My Care My Plan, and RCHC, to contribute to and facilitate community outreach, education, and dissemination of results. The CBO PPEA and SRCH Program Administrator will work with these groups, and others, to disseminate information and solicit stakeholder feedback regarding communication and information-sharing.

Program participants will also be encouraged to support and inform communication efforts through participation in the Committee, participation in patient advisory groups, and answering patient surveys. Since all printed materials, including summaries and results, will be available in both English and Spanish, clients will be invited to share this information with their community.

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

(1) Collaborative Care; (2) Depression; (3) Older adult; (4) Home visit; (5) Case Management

C) TIMELINE A) Specify the expected start date and end date of your INN Project B) Specify the total time frame (duration) of the INN Project C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

A. The expected start date of the project is **July 2021 and the expected end date is June 2024.**
B. The total time frame (duration) of the project is 36 months (3 years).
C. The key activities, milestones, and deliverables are included in the table below corresponding with the 12 quarters of the project.

* This timeline is dependent on the public review process and project approval by the MHSOAC.

PROJECT PLAN TIMELINE		
Quarter	**Activity/Milestone**	**Deliverable**
Q1 Jul-Sep 2021	**- Hire CCERP staff** **- Convene multi-disciplinary CCERP team** **- Begin development of the evaluation plan with specific metrics**	**- Staff hired** **- Team charter that defines roles, responsibilities, and work plan**
Q2 Oct-Dec 2021	**- Onboard and train staff** **- Solicit end-user feedback to share with committee** **- Finalize the evaluation plan** **- Begin build of queries and reports to track patient/program data** **- Develop bilingual materials for outreach, education and engagement**	**- Staff trained and oriented** **- Feedback analyzed and prepared for committee** **- Final evaluation plan** **- Bilingual printed materials**
Q3 Jan-Mar 2022	**- Convene Older Adult Steering Committee to refine project and evaluation** **- Identify clients in target population and begin providing depression intervention (traditional CoCM)** **- Complete the build of queries and reports to track patient/program data** **- Implement evaluation plan**	**- Project reviewed and refined based on feedback** **- First patient/clients begin being served** **- Completed reports in SRCH "Relevant" data-analytics platform** **- Program evaluation and data collection begin**
Q4 Apr-Jun 2022	- Client enrolled in Q3 begin receiving long term in-home care management	- Long-term care management begins for first set of clients
Q5 Jul-Sep 2022	- Reconvene Older Adult Steering Committee to continue refining project - Evaluate Year 1 progress and findings	- Project reviewed and refined based on feedback - Disseminate Year 1 progress to relevant groups and stakeholders

Q6 Oct-Dec 2022	- Annual survey administered to all CCERP clients	- Survey results received and evaluated
Q7 Jan-Mar 2023	- Clients continue to be enrolled in both phases of the program - Clients enrolled 1 year ago begin discharge from program	- Ongoing client services - First quarter with full year of client data to evaluate
Q8 Apr-Jun 2023	- Clients continue to be enrolled in both phases of the program	- Ongoing client services
Q9 Jul-Sep 2023	- Reconvene Older Adult Steering Committee to continue project refinement - Evaluate Year 2 findings - Evaluation report and preliminary findings review with DHS/BHD administration for sustainability	- Project reviewed and refined based on feedback - Disseminate Year 2 progress to key partners and County Behavioral Health - Sustainability planning begins
Q10 Oct-Dec 2023	**- Final clients enrolled in short-term phase of program**	**- Last quarter of new enrollments into program** **- Ongoing services for those already enrolled**
Q11 Jan-Mar 2024	**- Evaluation report draft presented to key partners and stakeholders for feedback** **- Case management focus on client transition**	**- Evaluation report finalized with input** **- Ongoing client services and transition planning**
Q12 Apr-Jun 2024	**- Complete evaluation and share internally with CCERP team** **- Develop summary of project results accessible in English and Spanish – share with Older Adult Steering Committee for feedback** **- Summary of project results shared with Sonoma County Behavioral Health**	**- Evaluation completed and shared internally** **- Summary shared with Older Adult Steering Committee** **- Summary of project results disseminated through all appropriate communication channels**

SECTION 4: INNOVATIONS PROJECT BUDGET AND SOURCE OF EXPENDITURES

A. Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

A&A requests $998,558 in MHSA Innovation funding to implement CCERP in collaboration with SRCH. To ensure funding supports direct services to the identified population, all project expenditures will pay for staffing costs as detailed in the attached budget. A&A and SRCH plan to leverage existing resources and funding streams and to that end will not request the standard indirect cost of 10%. Indirect costs such as communications, travel/mileage, printed materials, and operating costs, will be funded solely through in-kind match.

CCERP will be carried out by a program team comprising 1.0 FTE CBO Care Manager (embedded at SRCH), 0.5 FTE CBO Program Planning and Evaluation Analyst (PPEA), 0.1 FTE CBO Supervisor, 0.275 SRCH Program Administrator, 0.5 SRCH Care Coordinator/Patient Navigator, 0.1 SRCH Primary Care Physician, 0.013 FTE SRCH Psychiatric Consultant, 0.1 FTE SRCH RN Case Manager, 0.1 FTE SRCH Behavioral Health Manager Supervision, and 0.2 FTE SRCH Behavioral Health Provider.

In addition to patient/client services and day-to-day operations, CCERP staffing time includes participation in care management meetings, which will be held at SRCH and attended by all CCERP services staff. As clients demonstrate fewer depression symptoms over the nine-month case management period, their cases will be brought back to the multidisciplinary team for brief monthly or biweekly check-ins. Leadership staff and program staff from SRCH and A&A will also participate in quarterly project administration meetings

C. BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

To demonstrate their strong commitment to this work, A&A and SRCH plan to leverage existing resources and funding streams and will not request the standard indirect cost of 10%. Instead, all indirect costs will be funded solely through in-kind match, including expenses such as communications, travel/mileage, printed materials, and operating costs.

The A&A Section Manager, with support from A&A support staff, will contribute to program implementation, contracting, and reporting requirements as in-kind match, and A&A personnel benefits will be partially funded as match. Similarly, the SRCH Directors of Quality Integrated Behavioral Health Services, and Grants will provide evaluation, program, and grant support as an in-kind match.

SRCH will deliver CCERP services within the context of primary care delivery, integrated with essential mental and behavioral health care; this primary care infrastructure is supported through patient visit revenue and limited Health Resources & Services Administration (HRSA) grants. As introduced in Section IIc, PHC will provide training and technical assistance for CCERP staff on an as-needed basis at no cost to the county. Staff will participate in online trainings, accessible through the University of Washington, with whom A&A has worked extensively on the existing CoCM projects.

Funds Subject to Reversion

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 CCERP, to the MHSOAC in February 2021 following the public hearing on December 15, 2020 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.

B. BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY

Expenditures						
Personnel Costs	**FY21/22**	FY22/23	FY 23/24	TOTAL	Match	Total Project Cost
Salaries						
1.0 FTE CBO Care Manager	**$87,925**	$74,600	$50,775	$213,300	$0	$213,300
0.5 FTE CBO PPEA	**$48,600**	$41,200	$28,050	$117,850	$0	$117,850
0.1 FTE CBO Supervisor	**$9,830**	$8,340	$5,670	$23,840	$0	$23,840
0.275 FTE SRCH Program Administrator	**$34,046**	$28,218	$19,949	$82,213	$0	$82,212
0.5 FTE SRCH Care Coordinator/Navigator	**$43,264**	$35,858	$25,350	$104,472	$0	$104,472
0.1 FTE SRCH Primary Care Physician	**$25,293**	$20,963	$14,820	$61,076	$0	$61,076
0.013 FTE SRCH Psychiatric Consultant	**$4,992**	$4,138	$2,925	$12,055	$0	$12,055
0.1 FTE SRCH RN Case Management	**$12,913**	$10,702	$7,566	$31,181	$0	$31,181
0.1 FTE SRCH BH Manager Supervisor	**$14,643**	$12,137	$8,580	$35,360	$0	$35,360
0.2 FTE Behavioral Health Provider	**$23,962**	$19,860	$14,040	$57,862	$0	$57,862
Direct Costs						
CBO benefits @ 46%	**$67,323**	$57,104	$38,868	$163,296	$117,147	$280,442
Clinic benefits @ 25%	**$39,778**	$32,969	$23,307	$96,054	$0	$96,054
Indirect Costs	**$0**	$0		$0	$51,829	$51,829
Total Personnel Costs	**$412,569**	$346,089	$239,900	$998,558	$168,975	$1,167,534
Other Expenditures	**FY21/22**	FY22/23	FY23/24	TOTAL	In-Kind Match	Total Project Cost
0.025 FTE Director Integrated Behavioral Health	**$0**	$0	$0	$0	$12,364	$12,364
0.025 FTE Director Quality and Data	**$0**	$0	$0	$0	$12,364	$12,364
0.01 FTE Director Grants	**$0**	$0	$0	$0	$8,886	$8,886
Clinic benefits @ 25%	**$0**	$0	$0	$0	$8,403	$8,403
Indirect Costs	**$0**	$0	$0	$0	$52,229	$52,229
Total Other Expenditures	**$0**	$0	$0	$0	$94,246	$94,246
Budget Totals						
Personnel	**$305,468**	$256,016	$177,725	$739,209	$0	$739,209
Direct Costs	**$107,101**	$90,073	$62,175	$259,350	$168,976	$428,326
Other Expenditures	**$0**	$0	$0	$0	$94,246	$94,246
Total Budget	**$412,569**	**$346,089**	**$239,900**	**$998,558**	**$263,222**	**$1,261,780**

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 21/22**	**FY 22/23**	**FY 23/24**	**N/A**	**TOTAL**
1.	**Innovative MHSA Funds**	**341,620**	**285,932**	**198,947**		**826,499**
		0				
2.	Federal Financial Participation	**0**				
3.	1991 Realignment	**46,537**	**39,475**	**26,869**		**112,881**
4.	Behavioral Health Subaccount					
5.	Other funding* (Medi-Cal Reimbursements)	**39,029**	**32,349**	**22,868**		**94,246**
6.	Total Proposed Administration	**427,186**	**357,756**	**248,684**	**0**	**1,033,626**
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	**FY 21/22**	**FY 22/23**	**FY 23/24**	**N/A**	**TOTAL**
1.	**Innovative MHSA Funds**	**70,949**	**60,157**	**40953**		**172,059**
2.	Federal Financial Participation					
3.	1991 Realignment	**23,129**	**19,614**	**13,352**		**56,095**
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Evaluation	**94,078**	**79,771**	**54,305**	**0**	**228,154**
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 21/22**	**FY 22/23**	**FY 23/24**	**N/A**	**TOTAL**
1.	**Innovative MHSA Funds**	**412,569**	**346,089**	**239,900**		**998,558**
2.	Federal Financial Participation					
3.	1991 Realignment	**69,666**	**59,089**	**40,221**		**168,976**
4.	Behavioral Health Subaccount					
5.	Other funding*	**39,029**	**32,349**	**22,868**		**94,246**
6.	Total Proposed Expenditures	**521,264**	**437,527**	**302,989**	**0**	**1,261,780**
	*Other Funding is from Medi-Cal Reimbursements for SRCH					

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
May 27, 2021

Motion #: 1

Date: May 27, 2021

Time: 10:01AM

Motion:

The Commission approves the April 22, 2021 meeting minutes.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Danovitch

Motion carried 8 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	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
May 27, 2021

Motion #: 2

Date: May 27, 2021

Time: 10:45AM

Motion:

The Commission approves Ventura County's Innovation plan with a strong recommendation that the County establish an evaluation that addresses the sustainability factors or barriers that are identified in the analysis.

Name: Mobile Mental Health

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

Project Length: Four (4) Years

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Vice Chair Madrigal Weiss

Commissioner Berrick recused himself. 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
May 27, 2021

Motion #: 3

Date: May 27, 2021

Time: 11:28AM

Motion: The Commission approves Los Angeles County's request to change the reimbursement system that was in the original Trieste Innovation project plan and requests the County provide updates to the Commission every six months.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Danovitch

Commissioner Bunch recused herself. 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
May 27, 2021

Motion #: 4

Date: May 27, 2021

Time: 12:41PM

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

.

Commissioner making motion: Commissioner Tamplen

Commissioner seconding motion: Commissioner Bunch

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
May 27, 2021

Motion #: 5

Date: May 27, 2021

Time: 1:06PM

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

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Carnevale

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
May 27, 2021

Motion #: 6

Date: May 27, 2021

Time: 1:25PM

Proposed Motion:

The Commission supports Senate Bill 465 (Eggman).

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Carnevale

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 May Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0
17MHSOAC074	$ 0
18MHSOAC040	$ 0
Total	**$ 0**

Contracts with Deliverable Changes

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Kai LeMasson

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

Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Kai LeMasson

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

MHSOAC Staff: Dawnte Early

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

Total Contract Amount: $1,257,008

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	In Progress	06/30/2021	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
JUNE 2021

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	19	4	**23**
Participating Counties (unduplicated)	17	4	**21**
Dollars Requested	$34,585,872	$7,919,714	**$42,505,586**

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	15	14	$50,369,579	8

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	Madera	Project DAD (Dads, Anxiety & Depression)	$930,401.56	5 Years	3/3/2020	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	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
Under Final Review	Santa Clara	Independent Living Empowerment Project	$990,000	3 Years	6/29/2020	4/19/2021
Under Final Review	Humboldt	Resident Engagement & Support Team (REST)	$1,612,342	5 Years	4/6/2021	6/2/2021
Under Final Review	Orange	Multi-County Psychiatric Advance Directive Project	$12,888,948	4 Years	3/9/2021	5/19/2021
Under Final Review	Shasta	Multi-County Psychiatric Advance Directive Project	$630,731	4 Years	3/9/2021	5/19/2021

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Fresno	Multi-County Psychiatric Advance Directive Project	$500,000	5 Years	3/9/2021	5/19/2021
Under Final Review	Mariposa	Multi-County Psychiatric Advance Directive Project	$517,274	4 years	3/9/2021	5/19/2021
Under Final Review	Monterey	Multi-County Psychiatric Advance Directive Project	$1,978,237	4 years	3/9/2021	5/19/2021
Under Final Review	Stanislaus	Early Psychosis Learning Health Care Network	$1,564,633	5 Years	4/7/2021	6/2/2021
Under Final Review	Stanislaus	FSP Multi-County Collaborative	$1,757,146	4 Years	4/7/2021	6/2/2021
Under Final Review	Yolo	Crisis Now Planning Request	$114,000	One time use	5/4/2021	5/4/2021
Under Final Review	Merced	Transformational Equity Restart Program	$3,624,323.39	5 Years	3/19/2021	6/1/2021
Under Final Review	Imperial	Holistic Outreach Prevention and Engagement (HOPE)	$3,455,605	3 Years	4/30/2021	6/2/2021
Under Final Review	Colusa	Social Determinants of Rural Mental Health	$498,812	3 Years	4/17/2021	6/7/2021
Under Final Review	Butte	Physician Committed-Extension	$1,252,631	5 Years	4/12/2021	5/26/2021
Under Final Review	Amador	Student Mental Health Support	$665,000	5 Years	3/22/2021	5/19/2021
Under Final Review	Tri-Cities	Restorative Practices for Improving Mental Health	$949,957	3 Years	4/9/2021	5/27/2021

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
Santa Clara	Community Mobile Response Program (CMR)	$27,949,227	5/27/2021
Marin	From Housing to Healing, Re-Entry Community for Women	$1,795,000	5/27/2021
Ventura	Mobile Mental Health	$3,080,986	5/27/2021
Sonoma	Instructions Not Needed	$689,860	6/1/2021
Sonoma	Collaborative Care Enhanced Recovery Project (CCERP)	$998,558	6/1/2021

DHCS Status Chart of County RERs Received
June 24, 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 June 7th, 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.

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 2019-20 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.

To satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b) DHCS publishes MHSA funds subject to reversion which can be accessed at the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-County-Reversion-Enclosures.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	4/19/2021	5/27/2021
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	4/13/2021	4/15/2021
Imperial	2/1/2021	2/1/2021	2/12/2021
Inyo	4/1/2021	4/2/2021	
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
June 24, 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	4/29/2021	5/4/2021	5/13/2021
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	5/6/2021
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
June 24, 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	4/27/2021	n/a	5/21/2021
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	6/2/2021	6/3/2021	
Ventura	1/29/2021	2/2/2021	2/16/2021
Yolo	1/28/2021	2/2/2021	2/2/2021
Total	**56**	**55**	**53**

Mental Health Services
Oversight & Accountability Commission

Revised June 14, 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:** Held in Assembly Appropriations Committee - 2 Year Bill

Mental Health Services
Oversight & Accountability Commission

Revised June 14, 2021

Commission Co-Sponsored Legislation

- **Senate Bill 224, Senator Portantino: Pupil Instruction – Mental Health Education (Amended May 20, 2021)**

Summary: SB 224 requires each school district, county office of education, state special school, and charter school to ensure that all pupils in grades 1 to 12, inclusive, receive evidence-based, 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. This bill requires instruction to include, among other things, reasonably designed instruction on the overarching themes and core principles of mental health. SB 224 requires that instruction and related materials to, among other things, 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:** Assembly Education Committee. No scheduled hearing.

Mental Health Services
Oversight & Accountability Commission

Revised June 14, 2021

Commission Supported Legislation

➢ Senate Bill 465, Senator Eggman: Mental Health (Amended May 20, 2021)

Summary: SB 465 requires 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.

- ❖ **Position:** The Commission voted to support this bill at its May 27, 2021 meeting.
- ❖ **Location:** Assembly Health Committee. No scheduled hearing.

➢ 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 Appropriations Committee – No scheduled hearing.

Revised June 14, 2021

- **Senate Bill 14, Senator Portantino: Pupil Health – School Employee and Pupil Training – Excused Absences – Youth (Amended May 28, 2021)** - *Senate Floor Amendments* of 5/28/21 add an urgency clause.

  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:** Assembly Education Committee. No scheduled hearing.

- **Senate Bill 749, Senator Glazer: Mental Health Program Oversight and County Reporting (Amended May 25, 2021)**

  Summary: Current law requires the State Department of Health Care Services, in consultation with the commission and other entities, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, which identifies and evaluates county mental health programs funded by the MHSA. SB 749 will require, to the extent the Legislature makes an appropriation for these provisions, 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, including funding sources, funding utilization, and outcome data at the program, service, and statewide levels.

  - **Position:** The Commission voted to support this bill at its March 25, 2021 meeting.
  - **Location:** Assembly Health Committee. No scheduled hearing.

Mental Health Services
Oversight & Accountability Commission

Revised June 14, 2021

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:** Held in Assembly Appropriations Committee - 2 Year Bill

Schools and Mental Health

- **Assembly Bill 586, Assemblymember O'Donnell: School Health Demonstration Projects: Building and Sustaining K-12 School-Based Services (Amended May 24, 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, as provided.

  - **Location:** Senate Education Committee. No scheduled hearing.

- **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 – 2 Year Bill

➢ **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 – Held in Committee

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 – 2 Year Bill.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 6/14/2021

Agenda items and meeting locations are subject to change

July 22, 2021: NO MEETING

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.

OAC Budget Overview
The Commission will consider approval of its Fiscal Year 2020-21 Operations Budget and will hear an update on expenditures.

CCORE Team Overview and Discussion with the Commission
CCORE team members will present an update on the process to develop the Racial Equity Action Plan and provide Commissioners with a set of initial priorities for discussion.

Staff Report Out
Staff will report out on projects underway, and other matters relating to the ongoing work of the Commission.

September 23, 2021: TBD

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Staff Report Out
Staff will report out on projects underway, and other matters relating to the ongoing work of the Commission.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 6/14/2021

Agenda items and meeting locations are subject to change

October 28, 2021: TBD

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.

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, and other matters relating to the ongoing work of the Commission.

CCORE: Racial Equity Action Plan consideration for approval.
The Commission will consider approval and adoption of the Racial Equity Action Plan.

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.

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, and other matters relating to the ongoing work of the Commission.