WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
February 23, 2017

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

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Tina Wooton
Chair
John Boyd, Psy.D.
Vice-Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

February 23, 2017
8:30 A.M. – 3:00 P.M.
MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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

Public Notice

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

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

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters, assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting Cody Scott at (916) 445-8696 or email at mhsoac@mhsoac.ca.gov.

Tina Wooton
Chair

AGENDA
February 23, 2017

John Boyd, Psy.D.
Vice Chair

8:30 AM **Convene**
Chair Tina Wooton will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

8:35 AM **Announcements**

8:40 AM **Action**
1A: Approve January 26, 2017, MHSOAC Meeting Minutes
The Commission will consider approval of the minutes from the January 26, 2017, MHSOAC meeting.

- Public Comment
- Vote

Information
1B: January 26, 2017, Motions Summary
A summary of the motions voted on by the Commission during the January 26, 2017, Commission meeting.

1C: Evaluation Dashboard
The Evaluation Dashboard provides information on both executed and forthcoming MHSOAC evaluation and data strengthening efforts, including primary objectives, timelines, and deliverables.

1D: Calendar
The Calendar provides information on Commission and related meetings.

8:45 AM **Action**
2: Santa Cruz County Innovation Plan
County Presenters: Erik Riera, MBA, MED, CAS, Director, Mental Health and Substance Abuse Services; Pam Rogers-Wynam, LMFT, Director of Adult Services; Alicia Nájera, LCSW, Director of Watsonville Services

The Commission will consider approval of one Innovative Project Plan for Santa Cruz County.

- Public Comment
- Vote

9:40 AM **Action**
3: Merced County Innovation Plan
County Presenter: Sharon Jones, MHSA Coordinator

The Commission will consider approval of one Innovative Project Plan for Merced County.

- Public Comment
- Vote

10:35 AM **Action**

4: Riverside County Innovation Plan

County Presenters: Bill Brenneman, Deputy Director – Adult Services (Acting MHSA Administrator); Paul Thompson, Deputy Director – Children Services; Paul Gonzales, Administrative Services Officer, Fiscal; Suzanna Juarez-Williamson, Supervising Research Specialist; Diane Mitzenmacher, Supervisor Children Treatment Services

The Commission will consider approval of one Innovative Project Plan for Riverside County.

- Public Comment
- Vote

11:25 PM **Action**

5: Contract Authorization

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

The Commission will consider authorizing the Executive Director to enter into one or more contracts not to exceed $350,000 to support an Innovative event.

- Public Comment
- Vote

11:45 PM **General Public Comment**

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

12:00 PM **Lunch Break**

(Closed Session – Government Code Section 11126(a) related to personnel)

1:30 PM **Information**

6: The Role of Innovation in the Healthcare and Mental Health Industry

Presenter: Tom Insel, MD, Director, Clinical Neurosciences Verily Life Sciences/Google

Dr. Insel will give a presentation on opportunities to leverage innovation, data, and performance metrics to drive change in health and mental health care and improve public outcomes.

- Public Comment

2:30 PM **Information**

7: Executive Director Report Out

Presenter: Toby Ewing, Ph.D., will report out on projects underway and other matters relating to the ongoing work of the Commission.

2:45 PM **General Public Comment**

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

3:00 PM **Adjourn**

AGENDA ITEM 1A

Action

February 23, 2017 Commission Meeting

Approve January 26, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the January 26, 2017 meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the MHSOAC Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures: January 26, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve January 26, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the January 26, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
January 26, 2017

Sacramento County Office of Education
David P. Meaney Education Center, Board Room
10474 Mather Boulevard
Mather, California 95655

866-817-6550; Code 3190377

Members Participating

Tina Wooton, Chair
John Boyd, PsyD, Vice Chair
Reneeta Anthony
Lynne Ashbeck
Khatera Aslami-Tamplen
Senator Jim Beall
Itai Danovitch, MD
David Gordon
Gladys Mitchell
Larry Poaster, PhD
Richard Van Horn

Members Absent:

Sheriff Bill Brown
John Buck
Assembly Member Tony Thurmond

Staff Present

Toby Ewing, PhD, Executive Director;
Filomena Yeroshek, Chief Counsel;
Norma Pate, Deputy Director,
Program, Legislation, and Technology;
Brian Sala, PhD, Deputy Director,
Evaluation and Program Operations;
Fred Molitor, PhD,
Director, Research and Evaluation;

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:07 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Brian Sala, PhD, Deputy Director, introduced two new staff members: Tom Orrock, Health Program Manager, who will oversee the Triage Grant Program, and Sidney Armendariz, Health Program Specialist, who has joined the Innovation team. He stated additional staff will be added in February.

ACTION

1A: Approve November 17, 2016, MHSOAC Meeting Minutes

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

The Commission approves the November 17, 2016, Meeting Minutes.

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Ashbeck, Aslami-Tamplen, Danovitch, Gordon, and Van Horn.

INFORMATION

1B: November 17, 2016, Motions Summary

1C: Evaluation Dashboard

1D: Calendar

INFORMATION

2: Schools and Mental Health Project

Project Chair: Commissioner and Sacramento County Superintendent of Schools David Gordon

Commissioner Gordon stated several speakers and panelists will share their knowledge and experiences on the issue of early intervention to support children's mental health needs. He stated the goals of the Subcommittee: (1) bring education and mental health partners closer together to provide higher quality and more timely services; (2) encourage innovation in services for young children with mental health needs; (3) break the "fail first" paradigm and promote the earliest possible interventions with young people and families; and (4) head of early learning problems from becoming life-long problems. The project Subcommittee hosted its first public meeting on December 6th in Del Paso Heights to hear from members of the education and mental health communities. Also on that day, Senators Beall and Pan and other local officials joined the Subcommittee members, Commissioners Gordon, Mitchell, and Van Horn, on a school visit in Del Paso Heights at the Robla School District.

Partnership with the California Department of Education

Speaker: State Superintendent of Public Instruction Tom Torlakson

Tom Torlakson, the State Superintendent of Public Instruction, thanked Commissioner Gordon for his leadership, emphasis on innovation, and work on the pilot project focusing on school-based mental health services in early education. The state of California is recognized nationwide for its reforms in K-12 education and investing in career education.

Superintendent Torlakson stated he has worked on mental health issues for many years and was the co-chair with, now Mayor, Darrell Steinberg on Proposition 63. Superintendent Torlakson's goals are to improve services and expand treatment and enhance communication and coordination with schools, county mental health departments, the California Department of Education (CDE) Student Mental Health Policy Work Group, and the MHSOAC. He also thinks it is important to focus on promoting reaching and teaching the whole child.

Superintendent Torlakson spoke about the partnership of the CDE with the MHSOAC and the pilot project. Model programs have been identified, including the Unconditional Education (UE) model, funded by the CDE and implemented by the Seneca Family of Agencies, which has led to higher language and math scores, better attendance, and lower suspension and expulsion rates among the students in five schools in the Oakland district. Results were particularly promising for students with disabilities and African American, Latino, and English learner students. Leaders from this outstanding work will present to the Commission today.

Superintendent Torlakson stated he and his CDE team are committed to building the partnership and to looking for financial resources in the state budget to enhance the work, expand the connections, and strengthen the partnership. Working together can help more children succeed and achieve their dreams.

Panel 1: Family Members, Consumers, and Advocates Panel

- Daniela Guarnizo
- Liza Morris
- Kimber Rice
- Sean Rogers

Sean Rogers

Sean Rogers shared his story of living with mental health challenges since he was five-years-old. He performed well academically and thus was not noticed as having a problem until very late. He stated the need to look at children's socialization skills, self-control, and academic performance from preschool on as indicators of possible mental health illness. He stated the need to take children's behavioral problems seriously and to educate teachers to recognize mental health symptoms.

Commissioner Questions and Discussion

Vice Chair Boyd stated Mr. Rogers touched on a few things that could have made a difference back then, and one of them was the relationship with a teacher. He asked what other things could have made a difference in terms of helping identify what was going on and getting him to support sooner. Mr. Rogers stated he needed care and did not receive

it. Teachers can help by trying to understand that, even though students perform academically, they may not be developing psychologically in a healthy way.

Commissioner Van Horn asked what types of services and intervention would have made a difference for Mr. Rogers in preschool and kindergarten. Mr. Rogers stated he felt he would have benefited from early access to mental health care.

Commissioner Van Horn asked if a counselor or teacher who recognized mental health symptoms and understood how to discuss it with his family would have helped. Mr. Rogers stated, although the types of medications he requires are not available to children, someone he could have talked to and trusted and who put him in a situation where he could have been monitored would have been helpful so, as his symptoms became more obvious, further interventions would have been expedited.

Commissioner Mitchell stated trained professionals should be in schools to identify the difference and internal suffering in children with mental health issues versus the average baseline for children. Mr. Rogers agreed with the need to intervene as early as possible in a child's life to prevent the more noticeable symptoms that manifest later in life. He agreed that experts need to monitor early symptoms.

Daniela Guarnizo

Daniela Guarnizo stated her story and that of Mr. Rogers are different but align almost perfectly. She stated the National Alliance on Mental Illness (NAMI) gave her the tools she needed to accept herself and to seek treatment. She shared her story of living with mental health challenges since she was seven years old. She stated her symptoms were not ignored, but they were unnoticed because, like Mr. Rogers, she had good grades and was a model student. She stated the need for professionals at the school site who are trained to notice symptoms that do not look like symptoms. At the age of 15, she tried to take her life.

Ms. Guarnizo stated she found NAMI at the age of 18 when she again considered suicide because help was not given at school where she spent most of her time or at home because her family, although loving and supportive, did not understand. NAMI provided her with answers and helped her to understand that she was normal but needed more help – someone who could take care of her, tell her she was loved, and provide the tools for her to be successful. She stated she will always wonder how different it would have been if a counselor or teacher intervened the way that NAMI did. Even just having a school counselor available for her to talk to would have helped.

She stated the need for professionals at school sites and school-based programs for individuals like her, who cannot get help outside of school until they are old enough to seek it themselves. She stated her concern for individuals who did not find that help to become successful and are hospitalized time after time for the rest of their lives, end up in jail, or die. She stated she is successful today and loves her life, but no child should have to go through what she did.

Commissioner Questions and Discussion

Commissioner Mitchell stated she is hearing that early intervention from professionals is essential. She stated the need for a policy to allow professionals to be available at school

sites to help prevent mental health suffering beginning in the early years as described by the panelists today.

Vice Chair Boyd stated the Commission hears about the benefits of community and national-based programs such as NAMI. He asked what is unique or specific about being an immigrant in the school setting. Ms. Guarnizo stated she was in a middle-class neighborhood and went to good schools, but schools ignore that not everyone has the resources to seek help outside of school. Her parents worked 80 to 90 hours per week, as most immigrant parents of her classmates did. She stated sometimes students are seen only as students and not as individuals with individual needs.

Kimber Rice

Kimber Rice thanked Zima Creason, from the Mental Health Association in California (MHAC), for inviting her to speak today. She shared the story of her 10-year-old daughter who has lived with mental and developmental challenges since she was two years old. The severity of her symptoms increased over time. Ms. Rice's requests for help from the school were sidelined and ultimately ignored and no other options were suggested by the school. When her daughter was six, she sought outside help, but by this time the school suggested removing her to a special day class and did not offer supports or services. By age seven, her daughter's behavioral concerns increased. She received new labels and new prescriptions without the possibility of therapy, counseling, or behavioral supports. By age nine, her daughter began the intake process for Alta Regional Center and was placed on nine waiting lists. She received her first assessment last week at age 10-1/2. Ms. Rice stated the hope for resources and supports for her daughter and the rest of her family.

Commissioner Questions and Discussion

Commissioner Anthony asked if Ms. Rice and her husband have a support system to help them cope with the struggles with their child. Ms. Rice stated they have attended many information classes, but the best type of support they have found is networking with other parents. There are no formal groups.

Commissioner Van Horn stated regional centers are known for doing nothing for lots of people.

Vice Chair Boyd referred to the Mental Health Parity and Addiction Equity Act of 2008 and stated the Kennedy Forum, Steinberg Institute, and NAMI have stepped up and named parity and parity enforcement as a key priority moving into 2017. He suggested a Web site called Parity Track to empower individuals to exercise their rights.

Commissioner Ashbeck stated the panelists' stories highlight that the system is impossible to navigate. She stated the need for individuals to be able to navigate the system of care.

Commissioner Mitchell stated Ms. Rice's daughter is an example of the children she works with at a non-public, residential-based school. She asked Ms. Rice if she would be willing to try residential-based schools. Ms. Rice stated her daughter has successfully been included in a general education classroom for the past three years at her new school. She stated she feels a general education classroom provides a more successful and independent future.

Commissioner Gordon asked if the education and medical individuals Ms. Rice was working with collaborated. Ms. Rice stated they did not. She stated there is a lot of finger-pointing.

Liza Morris

Liza Morris shared the story of her 23 year old son who has lived with mental health challenges since he was two-years-old. The severity of his symptoms increased over time and his first hospitalization was at the age of seven. She described his illness as an invisible disability. She stated she sought medical treatment when he was four years old and felt lucky to live in an area with good mental health services, but at that time children, according to the DSM-IV, could not have a mental illness. It took several years and several doctors to determine that mental illness presents very differently in children.

She asked why her son had to get to such a low point before the doors were opened to him to receive services. She stated the need for greater consistency to help keep from adding to the problem, such as her son being put into a different program every time he returned from a hospitalization. The inconsistencies between the county and district, the imperative to mainstream children, the lack of medical professionals on the Individualized Education Program (IEP) team, and the ineligibility for supports and wraparound services were challenges she faced. In preparing for today's presentation she asked her son which of the education programs that he attended were the most successful in helping him. His response was that none of the programs in California were successful. The only program that helped him was a program in Idaho. That program was in a one-room schoolhouse with many trained staff. She stated she agreed with the other panelists that trained professionals at school sites are very important. Symptoms can be recognized as early as preschool.

Commissioner Questions and Discussion

Vice Chair Boyd asked Ms. Morris for comments or ideas about innovation or supports that could have made a difference for her in understanding her son's issues. Ms. Morris stated that making the issue more public and easier to talk about would have helped. In addition, doing some of the exercises that measure how children respond to emotional situations through technology, and providing educational computer games would have made a difference.

Panel 2: Teachers and School Personnel Panel

- Zenaida Agramonte, Social Worker at Bell Avenue Elementary School
- Margaret Jones, Licensed Educational Psychologist
- David Nelson, Principal and School Site Administrator, Valley Oaks Elementary School

David Nelson

David Nelson, Principal and School Site Administrator at Valley Oaks Elementary School in Galt, provided a brief summary of his background and history of working in low-income, English-learner schools. He mentioned that difficult family issues that children bring to the table play a large role in their mental health and affect their education and social skills development. He stated mental health issues are almost always connected to falling

behind educationally, which creates frustration and anxiety, leading to increased mental health needs.

Mr. Nelson stated educators in general are best at educating and are not mental health professionals; however, their experience oftentimes leads them to notice that something is not right. The thing that has benefited students the most is having someone who is trained – a counselor, outreach consultant, or social worker – on campus on a regular basis who students can talk to in a safe environment, who can establish a relationship with the students, and who can connect parents to resources.

Mr. Nelson suggested making full-time counselors and/or social workers a priority at all schools, but especially at high-need, high-risk schools. He stated the need for funds to be allocated to districts for the specific purpose of addressing mental health needs through hiring mental health professionals.

Commissioner Questions and Discussion

Commissioner Van Horn stated in all his years of education he never received instruction on pastoral counseling but had to figure it out on his own. He stated the same is true with teachers. He asked if Mr. Nelson received any kind of deep-level training during his education on recognition of mental health symptoms in children. Mr. Nelson stated he had one class during his education to become a teacher and administrator. There was nothing that prepared him for IEPs or to deal with students with significant mental health needs.

Commissioner Van Horn stated the need is not only to look at how to intervene with children from preschool on, but how to intervene with the education system in training teachers. Mr. Nelson agreed and stated ongoing training is necessary. An annual one-hour professional development is not enough.

Margaret Jones

Margaret Jones, a Licensed Educational Psychologist, agreed with Mr. Nelson's comment about the need for school-based counseling. She provided a brief summary of her background and role of serving as a site-based counselor in a variety of school settings. She stated the importance of collaborative teams and working with site-based administrators who support the work of the counselor and team. She felt the best collaborative team approach is Positive Behavior Interventions and Supports (PBIS), where school principals implement a tiered system of care approach. This approach provides interventions and positive behavior supports and does not wait for students to fail but identifies at-risk students early on.

Commissioner Questions and Discussion

Commissioner Mitchell suggested putting funding into teacher credentialing for consistency. Ms. Jones agreed and added the need not only for consistency but a standard of practice that is evidence-based and research-based.

Commissioner Danovitch asked the panelists for examples of schools or districts that are doing an outstanding job and what underlying factors make them stand out. Ms. Jones stated that it is training from people who know the PBIS systems approach with proactive

early intervention. Administrative support is key. Ms. Agramonte stated Placer County is a good model of an integrated system of care.

Zenaida Agramonte

Zenaida Agramonte, Social Worker at Bell Avenue Elementary, provided a brief summary of her background and her role in serving as the mental health clinician in a pilot program for a Prevention and Early Intervention (PEI) program funded last year. She agreed with Commissioner Van Horn about the credentialing issues and stated social workers are also not prepared for providing mental health services. She shared a case study as an example of what social workers and school counselors do on a daily basis with students. In that case she made a referral for mental health services for a student in January and in June she was still trying to help the student get services. It should not take this long to get a student into a program. She stated it is important to have shared, high expectations and to offer high supports. It is important to recognize the gaps and barriers that families and school staff run into because of the lack of an integrated system of care. There is a need for school social workers and counselors who have mental health training in every school district.

Commissioner Questions and Discussion

Commissioner Gordon thanked Ms. Agramonte for showing the group around her school on December 6th. He asked what the barrier is that takes six months to find out if services would be available when there is a mental health professional on staff and a proactive superintendent. Ms. Agramonte stated it is about not having an integrated system of care and the mistrust between schools, contract agencies, and the mental health system. She felt there was mistrust on the part of the providers that the school system or the school mental health professional understood what the student needed when she requested a higher level of care.

Highlighting the Need for School-Based Mental Health Services

Presenters: Ken Berrick, President/CEO, Seneca Family of Agencies; Jenny Ventura, Director, Unconditional Education Program, Seneca Family of Agencies; and Carl Sumi, Principal Scientist, SRI International

Ken Berrick

Ken Berrick, Founder/CEO, Seneca Family of Agencies, provided a slide presentation on the mental health needs in schools. He discussed the overlay between learning and emotional well-being and how poverty, trauma, and student achievement are all interconnected. He pointed out the importance of schools in addressing mental health needs. For example, children in preschool and elementary school with mental health needs are three times more likely to be suspended or expelled. Forty-four percent of youth in high school with mental health problems drop out and one in ten youth who drop out of school will end up incarcerated. Schools are the de facto mental health system for children. Mr. Berrick stated that providing services in schools can reduce barriers to access, reduce stigma and affordability and catch problems before they become severe. There is a need for integrated services. Mr. Berrick discussed the importance of integrated services in schools and the consequences of non-integrated approaches. Mr. Berrick stated the importance of the integration of school climate, school culture, and

mental health. An integrated approach results in positive mental health outcomes and positive education outcomes.

Jenny Ventura

Jenny Ventura, Director, Unconditional Education (UE) Program, Seneca Family of Agencies, continued the slide presentation and provided an overview of the alternative vision for what is possible – Multi-Tiered System of Supports (MTSS). She discussed the key characteristics of the MTSS and the UE tiered model. She also provided information about blended funding sources available for these programs.

Carl Sumi

Carl Sumi, Principal Scientist, SRI International, continued the slide presentation and provided an overview of the initial outcomes of the UE model being piloted in seven schools in Oakland.

Commissioner Questions and Discussion

Commissioner Danovitch asked if the UE schools have adopted the MTSS program. Commissioner Gordon stated that the MTSS is a model in which individuals can be trained in the schools. UE is very different because it includes the delivery of the services that flow from using an MTSS model. Mr. Berrick stated it does not matter what the implementation is; what matters is the delivery system.

Commissioner Beall stated the need for rethinking the delivery of health care services and that leadership is needed for that rethinking in order to ensure that children are getting adequate mental health services. He stated his intent to reintroduce an improved Senate Bill (SB) 113. There was opposition from individuals in the mental health community who did not support the priority and from school superintendents who did not believe that mental health should be in the school because it is not the school's business. Culture change is important in the new health care system. He invited Mr. Berrick to work with him to improve SB 113 to remove barriers.

Mr. Berrick agreed that IEPs are like a circular firing squad with the parent and child in the middle. The processes of the IEP and the delays that are generated in the current system are costly. He stated the need to overcome the misperception that there is a lack of services. It is a question of targeted allocation and demonstrating how resources can come together. Efficiencies can be created, particularly with special education and early intervention. Reducing stigma by increasing school climate and school culture as inclusive settings can help the systems work together.

Commissioner Anthony stated discussion on employment preparation and skills was missing from today's discussion. Support for the family and individual as they are going through this and continuing their education is a huge problem.

Public Comment

Michael Beebe, Public Policy Director, United Advocates for Children and Families (UACF), stated educating school staff is great, but parents need extra support. She stated the need for parent partners at every school.

Monica Nepomunceno, CDE, stated the Student Mental Health Policy Work Group has made recommendations to the California Commission on Teacher Credentialing (CTC) to include mental health curriculum in teaching and administrative credentialing programs. The CTC accepted the standards to include the mental health curriculum for the administrative credentialing program, but not for the teaching program. The teaching credentialing standard will not be updated for another ten years.

Deacon Donald Clark asked the Commission to inquire about Congresswoman Grace Napolitano's bill to increase the mental health presence in public schools and try to work in tandem between Commissioner Beall's and Congresswoman Napolitano's bills to change national policy. Also, genuine consumer empowerment is brought by parents of children in the schools and bridging must be considered between potential future federal and state legislation on this issue. Commissioner Beall stated churches are the bulwark of the safety net to keep individuals out of the jails. There is a need to work together as a team and get away from silos about churches, schools, and mental health. Churches are a key to keeping families together.

Anna Hasselblad, Steinberg Institute, stated it takes statewide leadership to ensure parity, integrated teams, and consistency in schools. The Steinberg Institute is dedicated to partnering with stakeholders across the state on PEI.

Ms. Rice cautioned that there are school districts that over-identify children for special education. She asked how that can be overcome. Commissioner Beall stated it is a state budget issue. The local funding formula will be amended to better identify children in need of special education.

Lydia Bourne spoke in support of school nurses who spend approximately 32 percent of their time providing mental health services. They are often the first to identify and assess physical and mental health issues.

Pamela McPhail stated under federal law children are to be identified and referred for assessment under special education. She invited everyone to visit the Children's Receiving Home of Sacramento's Sprouts Program, a program for trauma-focused, preschool-aged children.

Kathleen Casela, California Youth Empowerment Network (CAYEN), offered to work with the Commission on this important issue. The concept of family is broader especially for youths in foster care.

GENERAL PUBLIC COMMENT

Janet O'Meara spoke against continued Commission funding of the California Association of Local Behavioral Health Boards and Commissions (CALMHBC). She thanked Commission staff for looking into the issue.

Heidi Strunk, Advocacy Coordinator, California Association for Mental Health Peer-Run Organizations (CAMHPRO), stated that peer parent partners are a key component in services to help parents navigate challenges. She also asked to have trained mental health professionals at school sites.

Vickie Mendoza, Director, UACF, shared the story of her family and stated the need for advocates within the school system to connect with parents.

Stacie Hiramoto, Volunteer, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated her concern that the REMHDCO stakeholder contract was the only stakeholder contract that was not augmented and the contract ends in March. She stated that they had gone to the Legislature and got funding for fiscal year 2015-16. The funding was supposed to carry through the Requests for Proposals (RFPs) were award. In her opinion it will be lucky if the RFPs are signed in June or July. Executive Director Ewing stated the Legislature allocated $1 million for all the stakeholder contracts but because of budget language the funds did not become available in the year the Legislature authorized it. He explained the Commission's efforts to support the stakeholder contracts including going to the Legislature to seek permission to provide short-term sole source contracts for veterans and diverse racial and ethnic communities during this transition period of moving away from sole-source contracts and towards competitive contracts. As a result of that effort the Commission entered into a contracts including with REMHDCO for $200,000. When the RFPs were not awarded, staff met with each of the stakeholder contract holders to discuss the existing contracts and the need for augmenting the funds. At that time there $170,000 left on the $200,000 REMHDCO contract and thus, the contract was not augmented. The contract with the veterans organization was also not augmented for the same reason REMHDCO's contract was not augmented.

INFORMATION

3: <u>Overview of Governor's Proposed Budget for 2017-18</u>

Presenters: Kris Cook, Principal Program Budget Analyst, Department of Finance; and Jessica Sankus, Budget Analyst, Department of Finance

Jessica Sankus, Budget Analyst, Department of Finance (DOF), briefly summarized the projections of the revenues for the Mental Health Services Fund (MHSF) for the 2017-18 fiscal year (FY):

- A steady, marginal increase of $30 million
- An administrative cap of $94.4 million, which is an increase of $1.4 million from last FY
- Three additional MHSOAC staff positions beginning July 1, 2017:
    - $157,000 for 1 Associate Governmental Program Analyst to administer stakeholder contracts, including the $3 million in the grant program for children's crisis services
    - $309,000 for an Associate Governmental Program Analyst and a Health Program Specialist for implementation of regulations under Assembly Bill (AB) 82 and to provide technical assistance to counties for PEI programs.

Ms. Sankus stated the 2016-17 distributions to counties to date are approximately $916 million as of January of 2017.

Commissioner Questions and Discussion

Commissioner Poaster asked if the things that are currently in the five percent administrative cap will remain and if another $60 million can be expected for the California Reducing Disparities Project (CRDP).

Kris Cook, Budget Analyst, DOF, stated the estimated reserve for available administrative cap does take into consideration all past appropriations that have been made, but no new dollars will be disbursed to the CRDP. He stated he will email to staff the chart displaying the allocations. The chart is updated in March, July, and January.

Executive Director Ewing stated staff is working with the DOF to develop visuals that translate the complexity of the forecasts into lay terms. He asked when projections will next be updated for funding that is available that can be tapped by the Legislature beyond the allocated baseline. Ms. Sankus stated updated revenue estimates will be received in March from the Tax and Revenue Unit.

Commissioner Van Horn stated the CRDP is listed on the Commission's financial report as having $47,978,000. He asked if that amount has already been encumbered. Executive Director Ewing stated the DOF tracks funds the year they were received, allocated, and spent. It may look like more funds were allocated than received in a given year because funds have been rolled over from prior fiscal years. The $60 million total is $15 million times four years that is allocated to the CRDP. Additional funds become available as state administrative dollars are unspent. The DOF will know more in March.

Commissioner Anthony asked the presenters to report on the rationale behind projection changes in the future.

ACTION

4: Structure of Committees and Subcommittees and Announcement of Committee Chairs for 2017

Facilitator: Toby Ewing, PhD, Executive Director

Executive Director Ewing stated the need to clarify the rules about county Innovations and whether the Commission should establish either a committee or subcommittee to create a policy for the review and assessment of county Innovation plans. Per the Commission's Rules of Procedure standing committees are comprised of up to 15 public members. Subcommittees are comprised of Commissioners only. He asked Commissioners to discuss the structure to provide greater clarity and surety to the counties and stakeholders about what the Commission is looking for in Innovation proposals and how they would be processed.

Commissioner Questions

Commissioner Danovitch asked if the committees have charges. Executive Director Ewing stated the standing committees form a charter, at the beginning of the year, of tasks to accomplish, and subcommittees are tasked with a specific goal to present to the Commission.

Commissioner Danovitch stated the format depends on the goal. If the current Innovation process is not changed, a standing committee would be required to manage the work of reviewing Innovations, whereas a subcommittee goal could be to improve the Innovation application process and evaluation mechanism so that the action required from the Commission is based on the Innovation's strategic relevance as opposed to the merits of the application.

Executive Director Ewing stated Commissioners also noted that an opportunity is lost when counties do not bring their lessons learned back to the Commission so counties, stakeholders, and providers can learn collectively.

Commissioner Van Horn suggested that the Commission form a subcommittee made up of one to two Commissioners that has the freedom to call in experts to refine the process. He suggested that the subcommittee meet for a full day every other month or quarterly to review several proposals with witnesses from the counties before bringing the county Innovation plan before the Commission for approval. He suggested ongoing evaluation at the start of the Innovation process to determine if the Innovation will produce the expected outcomes. The Innovation regulations are inadequate to encourage true innovation and how it can be rewarded. He questioned if some county shares are too small to do Innovation or if some are too large and would require several Innovations. A subcommittee that includes expert counsel is the best way to begin to tackle this question.

Commissioner Aslami-Tamplen stated a subcommittee has more mobility and has the opportunity to gather more input. She suggested the formation of a standing committee in the future, after the subcommittee's findings and recommendations are presented to the Commission.

Chair Wooton suggested educating counties on innovative ideas. She agreed with the importance of sharing Innovation project outcomes with counties.

Commissioner Poaster stated the subcommittee would have at least three functions: defining Innovation, approving plans subject to full Commission approval, and recognizing truly innovative programs.

Executive Director Ewing stated there have been conversations between counties and stakeholders about the potential value of identifying key priorities shared among the counties. He suggested another point of inquiry for the subcommittee is an external process where the Commission facilitates dialogue statewide about areas that are deserving of innovation.

Vice Chair Boyd added that, over the past several months, the Commission has been reaching out to businesses, including members of the private sector, to figure out how to introduce those entities into the public sector and apply all the innovation they are doing to support the needs of the counties.

Commissioner Danovitch asked if the Commission has hosted an innovation conference for counties. Vice Chair Boyd stated that conversation is well on the way with more details to follow.

Action: Commissioner Van Horn made a motion, seconded by Commissioner Aslami-Tamplen, that:

The MHSOAC hereby establishes a subcommittee on Innovation, comprised of MHSOAC members, and the Commission Chair shall appoint members to that Subcommittee.

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Aslami-Tamplen, Danovitch, Gordon, Mitchell, Poaster, and Van Horn.

Executive Director Ewing stated there was no December meeting for the chair to appoint the chair and vice chair of the standing Committees.

Commissioner Poaster stated, historically, staff would create a Work Plan for the Commission with the Commission Chair and Vice Chair, which was adopted by the Commission in October. Elements of the Work Plan were given to the Committees and that became the basis of the Committee charters. There was discussion that the public should have the opportunity to define the charters.

Chair Wooton stated the Services Committee has not done much work recently due to the lack of resources and support. She suggested setting specific attainable goals that meet the needs of stakeholders.

Commissioner Anthony asked for a recommendation about the committees and subcommittees. Executive Director Ewing suggested that committees have narrowly-focused goals, driven by the needs of the Commission, and that members are appointed to each committee based on those goals. He stated the concern that, if committees create their own charters, most of the committee members are not Commissioners. He suggested that the Commission create the charter for each committee, appoint the chair, and authorize the chair to appoint the members of that committee, so the committees can get to work on their assigned goals.

Commissioner Van Horn stated that the CFLC and CLCC Committees have met concurrently for the past year it seems reasonable to combine them. They could be joined into one Community Input Committee with a two-prong charter – running a certain number of community forums per year throughout the state and ongoing training of the Commission in cultural, client, and family sensitivity.

Commissioner Aslami-Tamplen stated each Committee has been limited to 15 stakeholders. Between the two Committees, there are 30 Committee members and there are currently 20 to 30 applications for each Committee.

Executive Director Ewing suggested that the Chair appoint the chair and vice chair for the Research and Evaluation Committee and the Financial Oversight Committee and charge the chair and vice chair to develop a charter to present to the Commission. He also suggested the Chair table the Services Committee discussion, appoint the chair and vice chair for the CFLC and CLCC Committees, and consider, throughout the year, if they should be conjoined.

Chair Wooton announced the names of the chairs and vice chairs of Committees for 2017.

- **Research and Evaluation Committee (REC)**

Richard Van Horn, Chair; Larry Poaster, PhD, Vice-Chair; Itai Danovitch, M.D., Member

- **Financial Oversight Committee (FOC)**

John Buck, Chair; John Boyd, PsyD, Vice-Chair

- **Client and Family Leadership Committee (CFLC)**

Khatera Aslami-Tamplen, Chair; Gladys Mitchell, Member

- **Cultural and Linguistic Competence Committee (CLCC)**

Khatera Aslami-Tamplen, Chair; Reneeta Anthony, Vice-Chair

- **Services Committee**

On hold

Public Comment

Ms. Hiramoto stated the purpose of the Committees was in the spirit of the MHSA to be designed in collaboration with government and community. Committees are a way for members of the community to give input and interact with the Commission. The three-minute comment limitation is not enough collaboration. She stated the need for greater representation from communities of color on Committees and projects. She stated the CLCC and CFLC are both important Committees – combining them would be a disservice. She suggested a forum where individuals can provide input on the pros and cons of past processes. She stated there are individuals who want to be a part of the Services Committee. She stated the creation of Committee charters should be a collaborative process.

INFORMATION

5: MHSA 2017 Financial Report

Presenter: Brian Sala, PhD, Deputy Director

Brian Sala, PhD, Deputy Director, highlighted portions of the 2017 Financial Report, which was included in the meeting packet.

ACTION

6: Placer County Innovation Plan

Presenter: Brian Sala, PhD, Deputy Director

County Presenters: Maureen F. Bauman, LCSW, MPA, Director, Adult System of Care; Robert L. Oldham, MD, MSHA, Health Officer/Medical Director, Placer County Health and Human Services; and Jeff Brown, Director, Placer County Health and Human Services

Deputy Director Sala provided an overview, accompanied by a slide presentation, of the proposed five-year $3,900,000 Placer County Innovation (INN) project, titled “Homeless Integrated Care Coordination and Evaluation (HICCE).”

Jeff Brown, Director, Placer County Health and Human Services, introduced the members of his team. He stated the presenters will provide background information about the county and homelessness and an overview of the county’s proposal, highlighting its innovative features and learning objectives. He stated there has been a tremendous increase in the chronically homeless population over the last decade, which impacts neighborhoods and businesses along with the homeless individuals. As the county moves forward to strengthen the safety net, the county must find new ways to engage and educate the community, further engage with key stakeholders to gain their support, and find collaborative and sustainable ways to address this issue. He stated the county is

committed to ongoing evaluation efforts and bringing back those efforts to the Commission on a regular basis.

Robert L. Oldham, MD, MSHA, Health Officer/Medical Director, Placer County Health and Human Services, stated mental health, substance abuse, and homelessness are public health issues that the county faces. Placer County Public Health spent much of 2016 conducting its first Comprehensive Committee Health Assessment in almost 20 years, including an extensive survey, which ultimately identified addressing mental health, substance misuse, and particularly homelessness as public health priorities. Approaching these problems as public health problems will require a public health approach, including using community-level interventions addressing policy systems, environments, and other social determinants of health that impact the problem. A public health approach also involves using epidemiological tools to identify community characteristics and patterns and how they may impact the problem.

Dr. Oldham continued the slide presentation and discussed the demographics of Placer County and community concerns about the increasing homelessness in the county. He also discussed why the County's approach is innovative.

Maureen F. Bauman, LCSW, MPA, Director, Adult System of Care, continued the slide presentation and discussed how the proposed Innovation plan supports Placer County's priority to address homelessness. She summarized the evaluation tools and goals as well as the budget for the proposed Innovation project.

Commissioner Questions and Discussion

Commissioner Van Horn asked if one of the nurses is a nurse clinician. Ms. Bauman stated they will be public health nurses.

Commissioner Van Horn asked about the two clinician positions and the $62,000 annual total. Ms. Bauman stated they are Masters level staff or individuals who are working toward their Masters.

Chair Wooton asked if the county will hire bilingual staff. Ms. Bauman stated they will hire bilingual staff and will work closely with the Latino Leadership Council. Consumer and family advocates from the council and community will be included in the project to provide more effective outreach as part of the team.

Commissioner Aslami-Tamplen asked under what MHSA resource the project would continue and if the shared IT infrastructure would support PEI data collection efforts. Ms. Bauman stated past projects have gone into PEI and CSS and other projects have not continued. This project may be CSS, but the infrastructure data is already being built in for the case management model.

Commissioner Van Horn stated he is prepared to support the county's proposal if the county agrees to meet with the new Innovation Subcommittee at three-to-six-month intervals to assess if the project is doing what the county intended. This project is less about innovation and more about adaptation of existing models. There are some interesting pieces but it will be important to track how it is going.

Commissioner Gordon commended the county on their model of interagency collaboration and stated it should be emulated. He mentioned that during the morning panel presentations on school based mental health Placer was mentioned as having an excellent integrated system.

Commissioner Anthony asked how this project is innovative and how it differs from the project that the Substances Abuse and Mental Health Services Administration (SAMHSA) funded. Nancy Callahan, Evaluator, Placer County, stated the SAMHSA grant, Health 360, is about bringing primary care services into a behavioral health clinic. It is similar to, but much smaller than, the proposed project, which includes more partners. Dr. Oldham stated the SAMHSA grant services a different target population. It is facility-based for individuals who are already in the system with serious mental illness. The proposed project is a more intensive field-based effort. The target population is individuals who are homeless, many of whom will not be already engaged in the system.

Public Comment

Leslie Brewer, Director, Advocacy Services at the Placer Independent Resource Services, and Board President, Homeless Resources Council of the Sierras, spoke in support of Placer County's proposal. She stated she has been working on homelessness for over fifteen years. Placer County is finally to the point where there is a political will to address homelessness. This plan may not seem innovative, but it will be instrumental in getting the county, community, businesses, mental health providers, and nonprofits to finally work together for the best interests of those in the community who need help.

Makaila Cabral, Advocate, Advocates for Mentally-Ill (AMI) Housing, spoke in support of Placer County's proposal. She shared her story of being homeless for seven years with severe mental illness and substance abuse problems. She stated she advocates to prove that recovery is possible.

Janet O'Meara spoke in support of Placer County's proposal. She stated she served on the Mental Health Board of Placer County for six years, and she continues to be involved on the Adult Services Committee and attends the meetings of the MHSA Steering Committee. She stated the need for agencies to collaborate, for integrated services, and for strong data collection.

Janice LeRoux, Executive Director, First 5 Placer Children and Families Commission, and Vice President, California Association of Counties First 5 Commissions, spoke in support of Placer County's proposal. She stated innovation grants for particularly small counties are important. Small counties do a lot with a small amount of funding. She stated First 5 Placer has participated in the Steering Committee from the beginning in Placer County and has supported the plan as it has been developed. Although the county's proposal focuses on the adult population, it complements other efforts the county is undergoing with family-based homeless center services.

Jennifer Price, Executive Director, AMI Housing and Lead, Outreach and Stigma Reduction Subcommittee for the Campaign for Community Wellness, spoke in support of Placer County's proposal. She gave a summary of AMI Housing programs.

Katherine Ferry, Consumer Affairs Liaison in Placer County, NorCal Mental Health America, spoke in support of Placer County's proposal. She stated a healthy home is identified by SAMHSA as one of the four key components to recovery from mental illness.

Andrea Crook spoke about the compensation for advocates in Innovative projects in general. Advocates are educated and committed but bring an experience that cannot be learned in school. It is upsetting to see the compensation amounts being allocated in Innovation plan budgets. Peer services is now an evidence-based practice and is important for meaningful and successful outcomes. She stated the need to begin investing in peers.

Commissioner Van Horn asked for clarity on the peer advocate wages and benefits package. Dr. Oldham stated the subtotal of $323,112 is roughly 40 percent but is not evenly divided based on seniority. Mr. Brown stated the benefits package includes medical benefits and retirement.

Vice Chair Boyd stated the market needs to change as it relates to peer certification and funding steams to create sustainable jobs and sustainable salaries for individuals. He stated the need for appropriate reimbursement to cover the cost for these services.

Commissioner Mitchell asked what positions the peer advocates will hold. Ms. Bauman stated they will be counselor assistants, a regular county position, and will work with counselors in the field.

Action: Commissioner Van Horn made a motion, seconded by Commissioner Gordon, that:

The MHSOAC approves Placer County's Innovation Project, as follows:

Name: Homeless Integrated Care Coordination and Evaluation (HICCE)
Amount: $3,900,000
Program Length: Five (5) Years

Placer County shall provide updates on the HICCE Innovation Project to the Commission's Subcommittee on Innovation after three months and six months of operation.

Motion carried 6 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Aslami-Tamplen, Gordon, Mitchell, and Van Horn.

The following Commissioner voted "No": Commissioner Anthony.

INFORMATION

7: <u>Implementation Plan for the Regulations Report</u>

Presenter: Filomena Yeroshek, Chief Counsel

Filomena Yeroshek, Chief Counsel, disseminated copies of the final Prevention and Early Intervention and Innovation Regulations Project Report to Commissioners, which was adopted by the Commission in October 2016. She mentioned the next step is to implement the Commission's recommendations in the report. The Implementation Strategy document, included in the meeting packet, lists high-level strategies to turn the recommendations into reality. She highlighted two strategies in the document that involve creating subcommittees to work on amending the regulations and developing recommendations to support the needs of small counties.

ACTION

8: Evaluation Contracts

Presenter: Brian Sala, PhD, Deputy Director; Fred Molitor, PhD, Director of Research and Evaluation

Deputy Director Sala stated the need for additional contracts to support the transparency database project and additional work in evaluation to develop and implement surveillance reporting. He provided an overview, accompanied by a slide presentation, of the conceptual design for Phase 2 of the transparency database project, the Statewide Programs and Services Inventory. He also discussed the revised budget and provided a screenshot from the conceptual design for the Phase 2 that will provide information on the programs, providers and services. He then provided an online demonstration of the conceptual design, using Alameda County as an example.

Deputy Director Sala stated the intent of the online tool is to work with the counties to do the following:

- Validate provider users who will maintain their own data information on programs to enable the Commission to implement a variety of survey tools and to work with the counties.
- Collect other kinds of information from programs or from counties about programs.

Deputy Director Sala stated ultimately, outcome measures and descriptive attributes will be built in. Demographic pieces will also be built in for the PEI programs to facilitate the required demographic reporting at the program level on all PEI programs across the state starting at the end of this year.

Deputy Sala estimated that Phase 1, the Fiscal Transparency Tool, will be released in February.

Fred Molitor, PhD, Director of Research and Evaluation, continued the slide presentation and summarized the Full Services Partnerships (FSP) and non-FSP data and deliverables of the evaluation contracts.

Action: Commissioner Van Horn made a motion, seconded by Commissioner Mitchell, that:

The MHSOAC authorizes the Executive Director to enter into contracts for an amount not to exceed $510,000 for configuration specification and user acceptance testing of the Full Service Partnerships (FSP) and programs, providers, and services components of the MHSOAC Web application and database, and staff training on FSP and non-FSP data analysis:

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

The following Commissioners voted “Yes”: Chair Wooton, Vice Chair Boyd, and Commissioners Aslami-Tamplen, Mitchell, and Van Horn.

INFORMATION

16: Executive Director Report

Presenter: Toby Ewing, PhD, Executive Director

Executive Director Ewing presented his report:

Staff Changes/Vacancies

Three staff vacancies remain.

Biennial Report

The first Biennial Report for public dissemination will be presented at the next Commission meeting.

Mental Health Month

Staff is working in collaboration with other agencies on Mental Health Month activities for May 2017.

Legislation

Staff continues to work on the bills to revise the open meeting rules and to create a fellowship of consumers.

Stakeholder Contracts

Progress is being made on the RFP. The plan is to bring a proposal before the Commission at the March meeting to consider how to allocate $700,000 for TAY advocacy, apart from the existing contract currently in place.

Budget

The Governor endorsed the Commission's proposal for additional staff for the work that the Commission is doing.

Commission Meeting Calendar

The February meeting will be a business meeting in Sacramento.

The March meeting will be on the Criminal Justice Project in San Diego, paired with site visits.

The April meeting coincides with a large event at the Sacramento Convention Center, so hotel rooms may be a challenge.

Commissioner Questions and Discussion

Vice Chair Boyd asked staff to look at mobile crisis funding and if additional funding can be repurposed with a child crisis emphasis.

GENERAL PUBLIC COMMENT

Ms. Strunk spoke about the transparency of counties and how that pertains to the information of behavioral health boards. CAMHPRO is currently working on a project with SAMHSA to inventory consumers who sit on county boards. It is difficult to find that information. She asked that the Commission provide guidance and technical assistance to counties and encourage counties to make this information readily available on their websites. She reminded Commissioners that the CFLC and CLCC Committee members voted at the end of last year not to combine those Committees.

ADJOURN

There being no further business, the meeting was adjourned at 4:50 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
January 26, 2017

Motion #: 1
Date: January 26, 2017
Time: 9:14 a.m.

Text of Motion:

The Commission approves the November 17, 2016 Meeting Minutes.

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Ashbeck

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

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☒	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Buck	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Thurmond	☐	☐	☐
14. Commissioner Van Horn	☒	☐	☐

Motion #: 2
Date: January 26, 2017

Time: 2:25 p.m.

Text of Motion:

The Commission hereby establishes a Subcommittee on Innovation comprised of MHSOAC members and the Commission Chair shall appoint members to that Subcommittee.

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Aslami-Tamplen

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

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Buck	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☒	☐	☐
13. Commissioner Thurmond	☐	☐	☐
14. Commissioner Van Horn	☒	☐	☐

Motion #: 3
Date: January 26, 2017

Time: 4:19 p.m.

Text of Motion:

The MHSOAC approves Placer County's Innovation Project as follows:

Name: Homeless Integrated Care Coordination and Evaluation (HICCE)
Amount: $3,900,000
Project Length: Five (5) Years

Placer County shall provide updates on the HICCE Innovation Project to the Commission's Subcommittee on Innovation after three months and six months of operation.

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Gordon

Motion carried 6 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☐	☒	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Buck	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Thurmond	☐	☐	☐
14. Commissioner Van Horn	☒	☐	☐

Motion #: 4
Date: January 26, 2017

Time: 4:37 p.m.

Text of Motion:

The MHSOAC authorizes the Executive Director to enter into contracts for an amount not to exceed $510,000 for configuration specification and user acceptance testing of the Full Service Partnerships (FSP) and programs providers, and services components of the MHSOAC Web application and database; and staff training on FSP and non-FSP data analysis.

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☐	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Buck	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Poaster	☐	☐	☐
13. Commissioner Thurmond	☐	☐	☐
14. Commissioner Van Horn	☒	☐	☐

AGENDA ITEM1C

Information

February 23, 2017 Commission Meeting

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Evaluation Dashboard assists in monitoring the major evaluation efforts currently underway. The Evaluation Dashboard provides information, objectives, and the status of all current deliverables for internal and external evaluation contracts and projects. Below is a list of all changes/updates to all evaluation projects, which are highlighted in red within the Dashboard.

Changes/Updates:

External Evaluation Contracts

- **Full Service Partnership (FSP) Classification Project** *Mental Health Data Alliance (MHDATA)*
  Update: All reports under Deliverable 5 have been completed.

- **Recovery Orientation of Programs Evaluation** *The Regents of the Univ. of California, University of California, San Diego*
  Update: Deliverables 4 and 5 are under review.

- **Early Psychosis Evaluation** *The Regents of the Univ. of California, University of California, Davis*
  Update: Additional deliverable has been added to the project.

- **Assessment of System of Care for Older Adults** *The Regents of the Univ. of California, University of California, Los Angeles*
  Update: Due date for Deliverable 4 extended; Deliverable 4 is under review.

- **Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit** *The Regents of the Univ. of California, University of California, San Diego*
  Update: Deliverable 2 is under review.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

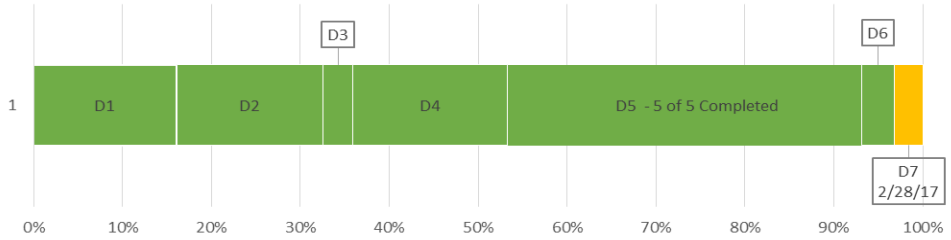
Motion: None

Snapshot of Contract Deliverables

FSP Classification Project

November 2014 - June 30, 2017

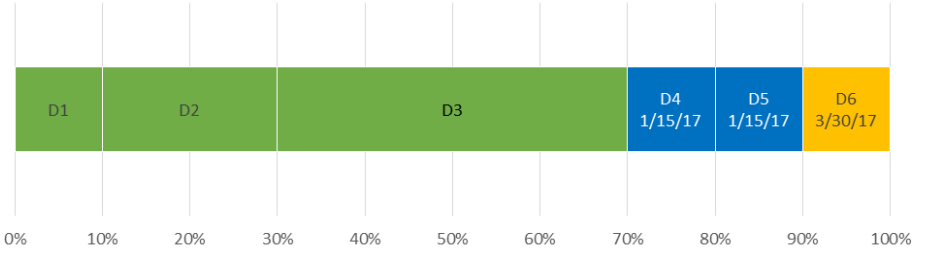
Assess Full Service Partnerships on a statewide level to enable clients, family members, providers, counties, and the State to further understand the diversity of FSPs across California.
(Contract Amount: $327,313)



Recovery Orientation of Programs Evaluation

January 1, 2015 - May 31, 2017

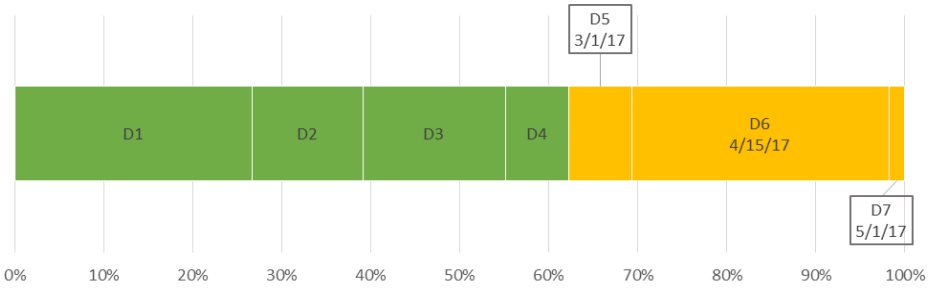
Identify, describe, and assess existing measures and methods of evaluating the recovery orientation of programs and services. *(Contract Amount: $500,000)*



Early Psychosis Evaluation

June 1, 2015 - June 30, 2017

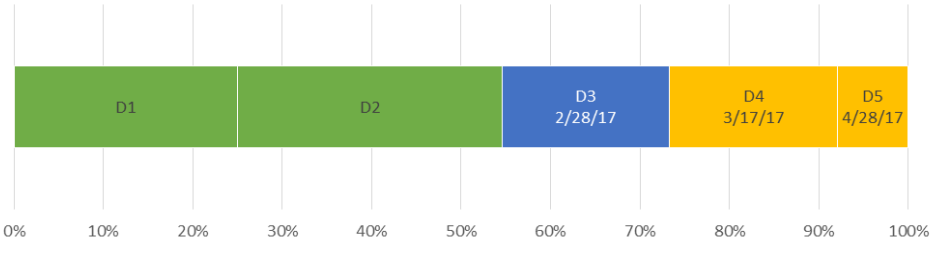
Identify and analyze program costs, outcomes, and costs associated with those outcomes related to providing early psychosis programs. *(Contract Amount: $281,151)*



Assessment of the System of Care for Older Adults

June 1, 2015 - June 30, 2017

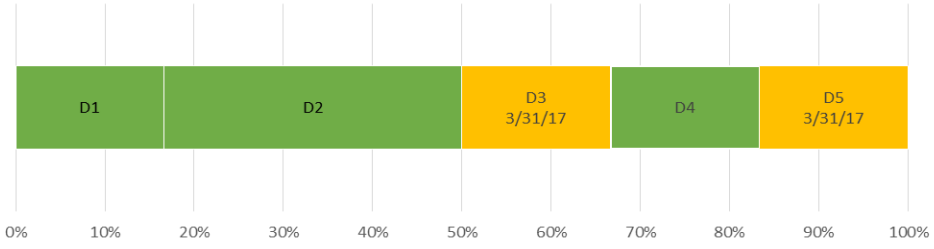
Assess the progress made in implementing an effective system of care for older adults with serious mental illness and identify methods further statewide progress in this area.
(Contract Amount: $400,000)



Evaluation of Return on Investment (ROI) for Prevention and Early Intervention (PEI) Evidence-Based Practices (EBPs)

June 30, 2015 - June 30, 2017

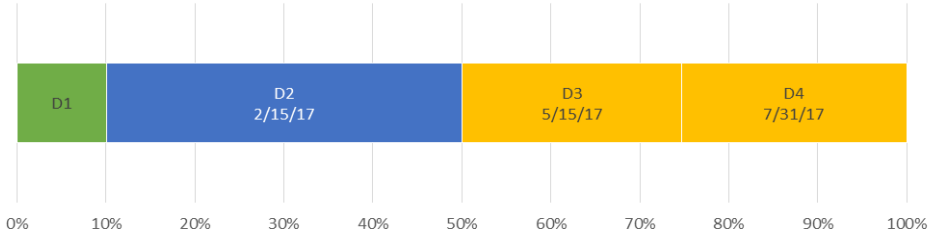
Investigate potential return on investment (ROI) for EBPs being implemented in CA with MHSA PEI funds, and to educate MHSOAC staff on ROI and other comparable evaluation methods.
(Contract Amount: $75,000)



Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit

August 15, 2016 - August 14, 2017

Assess the feasibility of adopting and implementing CSS Tracking, Monitoring, and Evaluation System to help providers, counties, and the State understand the clinical and functional status of clients within individual CSS programs/services, and determine whether clients are in appropriate services.
(Contract Amount: $99,000)



Legend: Deliverable Complete | Deliverable Pending | Deliverable Under Review

Lengths of deliverable segments are proportional to each deliverable's share of the overall contract budget.

MHSOAC Evaluation Dashboard February 2017

(updated 2/16/17)

Mental Health Services
Oversight & Accountability Commission

Current MHSOAC Evaluation Contracts and Deliverables

Mental Health Data Alliance (MHDATA)				
Full Service Partnership (FSP) Classification Project (14MHSOAC008)				
MHSOAC Staff: Brian Sala **Active Dates**: November 2014 – June 30, 2017 **Objective:** The original purpose of this evaluation effort was to classify Full Service Partnerships (FSPs) in a meaningful and useful fashion on a statewide level to support statewide assessment and evaluation. In mid-2016, a portion of this contract was amended to provide support for implementation of a broader MHSOAC data transparency tool.				
	Deliverable	**Due Date***	**Deliverable Cost**	**Status**
1	Preliminary Statewide FSP Classification System Presentation Based on Focus Groups and/or Interviews	February 27, 2015	$52,650	Completed
2	Report of Proposed Statewide FSP Classification System Based on Stakeholder Input	August 31, 2015	$53,750	Completed
3	Report of Final Statewide FSP Classification System Based on Public Comment	October 30, 2015	$11,225	Completed
4	Report of Online Statewide FSP Classification System Website Version 1.0 Design Specification	February 29, 2016	$56,900	Completed
5	MHSOAC Website Application Configuration Support and Documentation Monthly Progress Reports (5)	From Sept. 30, 2016 to January 31, 2017	$130,350	Completed 5 of 5
6	Fiscal Transparency Component Acceptance Support	October 31, 2016	$12,000	Completed
7	Final Report—MHSOAC Website Application Activities and Recommendations	February 28, 2017	$10,438	Pending
Total Contract Amount			$327,313	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard February 2017

(updated 2/16/17)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, San Diego

Recovery Orientation of Programs Evaluation (14MHSOAC003)

MHSOAC Staff: Ashley Mills

Active Dates: January 1, 2015 – May 31, 2017

Objective: To identify, describe, and assess existing measures and methods of evaluating the recovery orientation of programs and services, conduct an evaluation of the recovery orientation of direct and indirect services and/or programs provided within the Community Services and Supports (CSS) component (focused on the adult system of care), and use results from the evaluation to provide recommendations to providers, counties, and the State for achievement/promotion of recovery orientation in programs/services, as well as recovery and wellness of the clients that are served via these programs/services.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Report on Existing Measures of Recovery Orientation	June 30, 2015	$50,000	Completed
2	Report of Proposed Research Design and Analytic Plan to Evaluate the Recovery Orientation of Programs and Services	July 15, 2015	$100,000	Completed
3	Technical Report of Evaluation Results, Data, Stakeholder Materials, and Dissemination Plan	September 30, 2016	$200,000	Completed
4	Resources for Evaluating Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Under Review
5	Resources for Promoting Practices that Encourage Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Under Review
6	Report of Policy and Practice Recommendations for Ensuring, Maintaining, and Strengthening the Recovery Orientation of Programs and Services	March 30, 2017	$50,000	Pending
Total Contract Amount			$500,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard February 2017

(updated 2/16/17)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Davis

Early Psychosis Evaluation (14MHSOAC010)

MHSOAC Staff: Ashley Mills

Active Dates: June 1, 2015 – June 30, 2017

Objective: To identify and analyze program costs (i.e., costs expended to implement the program), outcomes (e.g., decreased hospital visits), and costs associated with those outcomes (e.g., costs associated with hospitalization) related to providing early psychosis programs. This evaluation will use data from the Early Diagnosis and Preventative Treatment of Psychosis Illness (SacEDAPT) program in Sacramento County to pilot a method to calculate program costs, outcomes, and costs associated with those outcomes in the SacEDAPT program, and to identify appropriate sources of comparison data (e.g., costs and outcomes during the period preceding SacEDAPT implementation). The evaluation will also develop and implement a method for identifying and describing all early psychosis programs throughout the State, including, for example, data elements collected by these programs and the various ways in which they are collected (e.g., via Electronic Health Records). These data elements will be used to review existing capacity to assess costs and outcomes for programs statewide, as well as help to define methods for the Sacramento County pilot. The Contractor further shall develop (with the involvement of stakeholders) a pilot study to examine and document how county early psychosis programs define, collect, and measure the duration of untreated psychosis (DUP).

	Deliverable	Due Date*	Deliverable Cost	Status
1	**Summary Report of Descriptive Assessment of SacEDAPT Early Psychosis Program**	**July 1, 2015**	**$75,000**	**Completed**
2	**Proposed Methodology for Analysis of Program Costs, Outcomes, and Changes in Costs Associated with those Outcomes in the SacEDAPT/Sacramento County Pilot**	**November 1, 2015**	**$35,000**	**Completed**
3	**Report of Research Findings from Sacramento County Pilot**	**July 1, 2016**	**$45,000**	**Completed**
4	**Proposed Plan to Complete the Descriptive Assessment of Early Psychosis Programs Statewide**	**October 1, 2016**	**$20,000**	**Completed**
5	**Summary Report of Descriptive Assessment of Early Psychosis Programs Statewide**	**March 1, 2017**	**$20,000**	**Pending**
6	**Report on the Pilot Study Findings and Recommendations for Measuring DUP and DUMI**	**April 15, 2017**	**$81,151.00**	**Pending**
7	**Proposed Statewide Evaluation Plan**	**May 1, 2017**	**$5,000**	**Pending**
Total Contract Amount			**$281,151**	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard February 2017

(updated 2/16/17)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Los Angeles

Assessment of System of Care for Older Adults (14MHSOAC016)

MHSOAC Staff: Brian Sala

Active Dates: June 1, 2015 – June 30, 2017

Objective: The purpose of this evaluation effort is to assess progress made in implementing an effective system of care for older adults with serious mental illness and identify methods to further statewide progress in this area. This assessment shall involve gauging the extent to which counties have developed and implemented services tailored to meet the needs of the older adult population, including un/underserved diverse older individuals, recognizing the unique challenges and needs faced by this population. In order to bolster the State's ability to promote improvements in the quality of services for older adults, a series of indicators shall be developed focused specifically on older adults with mental health issues; these indicators shall be developed with the intention of incorporating them into future data strengthening and performance monitoring efforts. The Contractor shall also identify and document the challenges and barriers to meeting the unique needs of this population, as well as strategies to overcome these challenges. Lessons learned and resultant policy and practice recommendations for how to improve and support older adult mental health programs at the State and local levels shall be developed and presented to the Commission.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Proposed Research Methods	September 7, 2015	$100,000	Completed
2	Recommended Data Elements, Indicators, and Policy Recommendations	June 30, 2016	$118,292	Completed
3	Summary and Analysis of Secondary and Key Informant Interview Data	February 28, 2017	$75,000	Under Review
4	Summary of Focus Group Data and Policy Recommendations	March 17, 2017	$75,000	Pending
5	Policy Brief and Fact Sheet(s)	April 28, 2017	$31,708	Pending
Total Contract Amount			$400,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Los Angeles

Evaluation of Return on Investment (ROI) for Prevention and Early Intervention (PEI) Evidence-Based Practices (EBPs) (14MHSOAC018)

MHSOAC Staff: Fred Molitor

Active Dates: June 30, 2015 – June 30, 2017

Objective: Through a previous MHSOAC contract, Trylon Associates Inc. studied the use and impact of Mental Health Service Act (MHSA) funds for PEI programs. Via this prior study, Trylon determined the total amount of MHSA PEI funds spent on PEI efforts during a designated time period; costs were broken down by program, among other things. The prior study highlighted the potential return on investment (i.e. cost savings) for PEI programs that were evidence based practices (EBPs), based on savings identified via implementation of such EBPs in other areas. The purpose of this evaluation is to investigate potential return on investment (ROI) for EBPs being implemented in California with MHSA PEI funds, and to educate MHSOAC staff on ROI and other comparable evaluation methods.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Fidelity Assessment Summary	March 31, 2016	$12,500	Completed
2	Report of Cost Savings from WSIPP-Documented EBPs: Fiscal Year (FY) 2011/2012 though FY 2014/2015	June 30, 2016	$25,000	Completed
3	Report of Cost Savings from WSIPP-Documented EBPs: FY 2011/2012 though FY 2015/2016	March 31, 2017	$12,500	Pending
4	Training/Technical Assistance (T/TA) Plan	August 1, 2015	$12,500	Completed
5	Training Manual and Summary of Training/Technical Assistance (T/TA)	March 31, 2017	$12,500	Pending
Total Contract Amount			$75,000	

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Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, San Diego

Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit (16MHSOAC016)

MHSOAC Staff: Fred Molitor

Active Dates: August 15, 2016 – August 14, 2017

Objective: Assist county behavioral health departments in assessing the feasibility of adopting and implementing a Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System designed to enable providers, counties, and the State to understand the clinical and functional status of clients within individual CSS programs/services, and determine whether clients are in appropriate services. The evaluation effort seeks to improve the MHSOAC's capacity to provide ongoing technical assistance to county behavioral health departments to track, evaluate, and compare CSS program outcomes.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Work Plan	October 15, 2016	$10,000	Completed
2	Draft County Toolkit	February 15, 2017	$39,500	Under Review
3	Regional Meetings Report	May 15, 2017	$24,500	Pending
4	Final County Toolkit and Report on Recommendations for Implementation of Toolkit	July 31, 2017	$25,000	Pending
Total Contract Amount			$99,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Mental Health Services
Oversight & Accountability Commission

Ongoing MHSOAC Internal Evaluation Projects

MHSOAC Evaluation Unit

Tracking and Monitoring of Mental Health Services Act (MHSA) Programs and Activities via Plans, Updates, and Expenditure Reports

MHSOAC Staff: TBD

Active Dates: December 2013 – TBD

Objectives: Develop and implement a system for extracting and utilizing information of interest for tracking and monitoring MHSA program activities and outcomes for fiscal year (FY) 2011/12 and FY 2012/13 from County Annual Updates, Three-Year Plans, and Annual Revenue and Expenditure Reports. Consider what additional information may be useful to capture via the reporting process.

This internal evaluation project is in transition to an external evaluation project.

	Work Effort or Product	Due Date	Status
1	Determine State Needs For Information That Is Currently Provided Within Reports	March 31, 2014	Completed
2	Develop System For Extracting And Cataloging State's Data Needs	April 30, 2014	Completed
3	List Of Recommended Data Elements	June 16, 2014	Completed
4	Complete Construction Of Tables	August 15, 2014	Completed
5	Test Database Functionality	August 22, 2014	Completed
6	Complete Construction Of Queries And Forms	TBD	Pending
7	Use System To Extract And Catalog Data Needed By State For FY 2012/13	TBD	Pending
8	Data Quality Check	TBD	Pending

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard February 2017

(updated 2/16/17)

Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Unit

Mental Health Services Act (MHSA) Performance Monitoring

MHSOAC Staff: Brian Sala

Active Dates: Ongoing

Objectives: Implement a process and system for monitoring and reporting on individual- and system-level data, including the CSI and DCR, to support characterization and assessment of MHSA programs and outcomes.

This internal evaluation project is in transition to an external evaluation project.

	Work Effort or Product	Due Date	Status
1	Develop Process For Adding Additional Client, System, And Community-Level Indicators	December 31, 2014	Completed
2	Secure Health Insurance Portability And Accountability Act (HIPAA) Compliance For MHSOAC Staff And Information Systems To Allow Secure Storage And Analysis Of Client-Level Data	May 31, 2015	Completed
3	Descriptive Statistics Report of Key CSI Data Elements, by County	April 30, 2016	Pending
4	MHDA Development and Training of EPLD Templates and Protocols for Analysis of DHCS Databases	May 15, 2016	Pending
5	Develop Strategic Plan Identifying Specific Research Questions Assessing Aspects of the Mental Health System and the Impact of the MHSA	TBD	Pending
6	Web-based Dynamic Visual Analytics of Key Data Elements	TBD	Pending
7	Develop and Implement Strategic Plan for Assessing Aspects of the Mental Health System and the Impact of the MHSA	TBD	Pending

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Mental Health Services
Oversight & Accountability Commission
1325 J ST STE 1700
SACRAMENTO CA 95814
(916) 445-8696
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Commission Meeting Schedule 2017

Meeting Date and Location	Group / Topic
Thursday, February 23, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, March 23, 2017 San Diego	**Commission Meeting** Mental Health/ Criminal Justice
Thursday, April 27, 2017 Out of Town	**Commission Meeting** Business Meeting
Thursday, May 25, 2017 Sacramento	**Commission Meeting** Mental Health /Schools
Thursday, June 23, 2017 No Meeting	**Commission Meeting** No Meeting
Thursday, July 27, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, August 24, 2017 Out of Town	**Commission Meeting** Project Meeting
Thursday, September 28, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, October 26, 2017 Out of Town	**Commission Meeting** Project Meeting
Thursday, November 16, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, December 28, 2017 No Meeting	**Commission Meeting** No Meeting

AGENDA ITEM 2

Action

February 23, 2017 Commission Meeting

Santa Cruz County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Santa Cruz County's request to fund a new Innovative project: Integrated Health and Housing Supports (IHHS) for a total of $4,451,280 in Innovation component funding over five (5) years. The IHHS project proposes to combine the model of Permanent Supportive Housing with intensive health care needs monitoring and peer support services for individuals who have co-occurring psychiatric and other health conditions.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

The IHHS project includes using Innovation to establish sixteen (16) new housing units located throughout the County and hiring a team consisting of 1.0 FTE Occupational Therapist, 2.0 FTE RN/LVN, 2.0 FTE Housing Support Case Managers, and 3.0 FTE Peer Support Housing Specialists. The team will provide the health care monitoring and coaching, and on-site peer support to ensure that acute health and other health needs are addressed. The INN project complies with all MHSA requirements.

Presenters:

- Erik Riera, MBA, MED, CAS, Director, Santa Cruz County Mental Health & Substance Abuse Services
- Pam Rogers-Wynam, LMFT, Director of Adult Services, Santa Cruz County Mental Health & Substance Abuse Services
- Alicia Nájera, LCSW, Director of Watsonville Services, MHSA Coordinator, Santa Cruz County Mental Health & Substance Abuse Services

Enclosures (3): (1) Staff Commission Meeting INN Regulatory Handout; (2) Staff Innovation Summary, Integrated Health and Housing Supports (IHHS); (3) Santa Cruz County Innovation Brief.

Handout (1): PowerPoint Presentation

Additional Materials (1): A link to the County's complete Innovation Plan is available on the MHSOAC website at the following URL: http://mhsoac.ca.gov/document/2017-02/santa-cruz-county-inn-plans-avenues-and-integrated-health-and-housing-supports-ihhs

Proposed Motion: The MHSOAC approves Santa Cruz County's Innovation Project, as follows:

Name: Integrated Health and Housing Supports (IHHS)

Amount: $4,451,280

Project Length: Five (5) Years

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Innovation Regulatory Handout

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

Staff Summary Analysis Includes:

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

STAFF INNOVATION SUMMARY— SANTA CRUZ

Name of Innovative (INN) Project: Integrated Health and Housing Supports (IHHS)

Total INN Funding Requested for Project: $4,451,280

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: January 24, 2017

County Submitted Innovation (INN) Project: January 25, 2017

MHSOAC Consideration of INN Project: February 23, 2017

Project Introduction:

Santa Cruz County proposes to develop an Integrated Health and Housing Supports (IHHS) program for individuals who have co-occurring psychiatric and other health conditions. The County proposes to combine the model of Permanent Supportive Housing with intensive health care needs monitoring and peer support services. The County proposes to lease residential units and provide in-home telehealth monitoring devices that are connected to a patient portal that is monitored by medical staff.

In the balance of this brief we address specific criteria that the OAC looks for when evaluating Innovation Plans, including: What is the unmet need that the County is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the County to make any conclusions regarding their learning objectives? In addition, the OAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County states that it has established Permanent Supportive Housing programs to address the needs of individuals with mental illnesses. The County states that individuals with co-occurring medical conditions are disproportionately in Mental and Health Rehabilitation Centers and Board and Care facilities because they need continuous

health monitoring. Also, the County's Mental Health and Substance Abuse 2015 Strategic plan identified independent housing for individuals with co-occurring disorders as a need to reduce the use of higher level care settings.

The Response

Santa Cruz County proposes to develop an Integrated Health Supportive Housing program to serve up to sixty (60) individuals annually who have co-occurring psychiatric and other health conditions. It appears the County wants to test if using the well-established best practice to reduce homelessness, Permanent Supportive Housing, in conjunction with peer support (trained in Intentional Peer Support) helps improve engagement to treatment. Secondly, it appears Santa Cruz County wants to determine if providing telehealth monitoring devices in the individual's permanent housing facility improves their health outcomes. The County may wish to provide further clarification on the connection between the two components of their projects and how it relates to improved mental health outcomes. The program includes using Innovation to establish sixteen (16) new housing units located throughout the County and hiring a team consisting of 1.0 FTE Occupational Therapist, 2.0 FTE RN/LVN, 2.0 FTE Housing Support Case Managers, and 3.0 FTE Peer Support Housing Specialists to provide the health care monitoring and on-site peer support. The County may consider elaborating on how other funding sources such as No Place Like Home could not support establishing more permanent housing options for this target population, including the implementation of on-site case management services.

Other Permanent Supportive Housing programs have used peer support to provide more on-site case management and supportive services to the residents. It appears Santa Cruz wants to use peers offering the promising practice, Intentional Peer Support, already currently implemented, to enhance the delivery of services to the target population. Santa Cruz may wish to expand on how the core principles of the model paired with peers will impact the service delivery to the target population. The County may wish to differentiate the roles of the Peer Support Housing Specialists and the Housing Support Case Managers.

Several health systems use telehealth monitoring devices for cardiac conditions and diabetes and find it useful with gathering more accurate data. Examples can be found in the Reference section. The County may wish to expand on the connection of monitoring real-life health data to improved mental health outcomes. Research shows adults living with serious mental illnesses die twenty-five years earlier than their peers without mental illnesses, largely due to treatable health conditions. The County may wish to expand on how supporting the medical needs will directly affect the mental health needs, especially given the specific target population has not been clearly defined.

MHSOAC recognizes that combining these aspects may be innovative to the mental health field. This plan may satisfy the need of providing supportive housing to individuals residing in restrictive mental health facilities who need more health monitoring due to co-occurring conditions. The combination of permanent housing, telemonitoring, and peer

support to provide services to individuals with co-occurring health conditions supports the project's objective of determining if managing co-occurring disorders will encourage independent housing. The County is encouraged to further clarify how this relates back to improving the mental health outcome.

The Community Planning Process

The MHSA regulations indicate stakeholder participation should be present at every step of the way for Innovation Projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the County presents for meeting this requirement.

The Board of Supervisors approved this Innovation Plan on January 24, 2017. The County states the MHSA Steering Committee managed the community planning process. From September through January 2015, the County held community meetings to develop a Mental Health Strategic Plan, which identified the need for this project. Then, the County held focus groups for underrepresented populations, including families, older adults, veterans, Lesbian, Gay, Bisexual, Transgender, and Queer youth, Spanish speakers, and transitional age youth. In May, 2016, the County held two stakeholder meetings to discuss Prevention & Early Regulations and innovative projects, which included consumers, family members, and providers. The proposal was posted for public comment from September 19, 2016 to October 19, 2016. The County held a public hearing for comments on October 20, 2016. The County may wish to clarify the list of stakeholders in their proposal by expanding on the roles of the groups represented at the meetings to plan Innovative project.

The County indicates some of their population is mono-lingual Spanish Speaking. They are encouraged to provide additional information on how the County will incorporate cultural competence into their project.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how the County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

In its proposal, Santa Cruz County states its learning goal is to improve health measures in areas of diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), and obesity. The County intends to use a participatory approach to evaluate the program, in which stakeholders will be asked for their input on evaluation questions, measures, data collection procedures, and interpreting findings. The evaluation will focus on answering four questions:

1. Is there an improvement in health measures in areas of diabetes, hypertension, COPD, and obesity?
2. Are consumers with co-occurring mental health and other health conditions able to live successfully in independent housing in the community?
3. Is there an increase in consumer socialization and community engagement?
4. Is there an improvement in consumer satisfaction with their living situation?

The County describes the project's objective as testing if a program manages an individual's co-occurring physical and mental health conditions, he or she will be able to live independently. The County intends for this project to decrease the burden on skilled nursing facilities and encourage individuals with co-morbidities to live independently in the community. Santa Cruz County is encouraged to expand on how their learning objective relate to the identified staff and components of their innovative project.

The County states if the project is successful, it will reduce the need for placements in skilled nursing facilities. It will redirect the savings back to this project to provide ongoing support for these individuals. The County will maintain the housing units because the stakeholders identified affordable housing as a priority in its strategic plan.

The Budget

This section addresses the County's case for the scope of their project, the length, and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The total budget for Santa Cruz County's Innovative project is $4,451,280 over five (5) years. The County provided a detailed budget narrative and detail about the projected expenditures and funding sources.

The total budget allocates $1,701,807, roughly 37% of Innovation Funds, to hire:

1.0 FTE Occupational Therapist
2.0 FTE Registered Nurses/Licensed Vocational Nurses
2.0 FTE Housing Support Case Managers
3.0 FTE Peer Support Housing Specialists.

The total budget allocates $1,298,710, which is 29% of the Innovation Funds, for a contract for Master Leasing/Rent Subsidy with Front Street, Incorporated for scattered site housing units. The total budget allocates $225,000, which is 5% of the Innovation Funds, for evaluation. The total budget allocates $344,880, which is 7.5% of the Innovation Funds, for the telehealth devices and contracting services. The total budget includes $12,980 for operating costs and $580,601 for administrative expenses.

The yearly budget averages $545,160.

Additional Regulatory Requirements

Commission staff finds the County proposal has met minimum regulatory requirements, and Santa Cruz County may wish to provide further clarification on how this project contributes to learning through innovation due to their prior success with peer services and IPS.

References

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Santa Cruz County Innovation Project Brief

Name of INN Project: Integrated Health and Housing Supports (IHHS)

Total INN Funding Requested for Project: $4,451,280

Duration of INN Project: Five (5) years

Review History:
The IHHS plan was approved by the Santa Cruz County Board of Supervisors on January 24, 2017. The date for the Mental Health Oversight and Accountability Commission consideration of the INN project is February 23, 2017.

Project Introduction:
Santa Cruz County is seeking to combine a number of approaches to assist consumers with serious mental illness in succeeding in community-based independent housing. First is utilizing the Permanent Supported Housing model for consumers with co-occurring mental health and health conditions by adding an integrated health model that would allow home-based telehealth monitoring and care for consumers with health conditions such as diabetes, obesity, hypertension and COPD. By providing an electronic telehealth monitoring device in the home, the consumer could monitor specific psychiatric and other health conditions, linked to a confidential and HIPAA compliant web-based program to communicate with nursing staff. In person home-based nursing and case management staff would be part of the Integrated Health and Housing Support Team. Finally the Integrated Health and Housing Support team would include peers trained in Intentional Peer Support (IPS) to provide independent living skills building and support, social engagement and modeling for community integration.

The Need:
Santa Cruz County has a long standing challenge of limited affordable housing for the general population, but the issue is exacerbated for individuals with psychiatric disabilities that depend on a social security income of $890 to $1145 (determined according to work history). Current fair market rent for a one bedroom unit for a single adult is $1500 per month in Santa Cruz County. Permanent Supported Housing programs have been established to address the needs of this population, providing a combination of rental assistance and housing supports for individual participants, but individuals with co-occurring medical conditions disproportionately remain in locked Mental Health Rehabilitation Centers and Board and Care facilities due to the need for monitoring of mental health and other chronic health conditions. In addition, individuals with severe mental illness have been shown to have a 25 year shorter life span than the general population. Untreated or undertreated life threatening chronic health conditions such as diabetes, COPD, obesity and hypertension have a direct impact on life expectancy.

The Response:
The proposed Innovative Project for Santa Cruz County is an Integrated Health and Housing Supports (IHHS) program utilizing intensive support services in a multidisciplinary approach to allow the consumer to live in the least restrictive setting. . Program participants will be up to 60 consumers annually who (1) have co-occurring psychiatric and other health conditions, and (2) have a primary care physician in the County operated Federally Qualified Health Clinic and (3) require intensive housing supports to live in the community due to their mental illness, substance use disorder and co-occurring health condition

(4) are interested in participating in the program voluntarily. The proposed program will provide an alternative option to more restrictive placements such as locked care and/or board and care.

The IHHS multidisciplinary team will consist of mental health clinicians who will support behavioral health care and recovery goals, utilizing case management interventions, Cognitive Behavioral Therapy, DBT and Motivational Interviewing. The Occupational Therapist will work with consumers to develop functional skills for independent living. Nursing staff will provide home-based medication management support. Nursing staff will also provide the monitoring of the telehealth device, linkages to medical appointments, linkages to psychiatric appointments and provide continuity of care across the domains. The Medical Assistant will work with the Psychiatrist and program consumers to coordinate services and provide support to the treatment team, Family members, while visiting their family members in the community, will be supported through training in a program specially designed for family members in Cognitive Behavioral Therapy for Psychosis, to provide early identification of issues needing the attention of the treatment team. Finally the use of Peer Support staff is integral to stabilizing the consumer in the housing environment. Peers will provide monitoring of the individual's progress, assistance with community integration and community engagement, modeling for successful management of psychiatric symptoms and linkages to natural supports.

All members of the IHHS staff will work closely with mental health and medical staff to understand the complexities of the mental health and health conditions experienced by the participants. Training will be provided to all staff in various psychiatric and health conditions, inclusive of understanding symptoms, medication management needs and interventions. As part of the IHHS model is an after-hours on call crisis response system for psychiatric emergencies. Health emergencies after hours will be handled through urgent care sites and the Emergency Medical Service system.

Residential units will be master-leased by a contract partner, and each unit will be equipped with an automated telehealth monitor following County procurement, and potentially other technology assisting devices such as automated medication dispensing devices and wrist fall monitoring devices that will support the goals and objectives of the project. The telehealth monitoring device is capable of monitoring multiple conditions such as hypertension, COPD, CHF and diabetes, as well as prompting the client around medication adherence. The device provides prompts to the consumer both visually and auditory to check key health indicators and then provides confidential reports to the nursing staff to monitor. The nurse will be able to respond promptly to indicators such as high blood pressure or blood sugar that might otherwise go unchecked between medical appointments. This telehealth monitoring device will be key to stability for these consumers living independently in the community. Program participants will be consumers connected to services through the County Health Services Agency.

Santa Cruz County Mental Health and Substance Abuse Services is committed to supporting consumers with serious mental illness to live in the least restrictive setting in the community with a model based on evidence based housing programs, combined with enhanced support for other health conditions. Supporting Recovery of mental health, substance use disorders and chronic health conditions increases the consumer's ability to live independently in the community.

The Community Planning Process:
In the summer of 2014, Santa Cruz County Mental Health & Substance Abuse Services launched a series of community meetings in order to develop a Mental Health Strategic Plan, which were held from September through January 2015. One of these meetings specifically focused on the requirements of Innovative Programs. The announcement of these meetings was disseminated to all stakeholders, as

well as posted in three local newspapers each month. (Notes from these meetings were posted on our website.)

The initial meetings were held in September and allowed everyone to be heard by use of small discussion groups. They informed us about gaps in our services, and what (and how) services could be improved. The majority of the participants were adults aged 26 to 59 (72%), and thirty-seven (37%) identified as clients/consumers.

Based on a review of the participants in these meetings, we held focus groups for groups that were under-represented. The groups were: families, older adults, veterans/veteran advocates, LGBTQ youth, monolingual Spanish speakers, and transition age youth. Additionally, the Santa Cruz County Sheriff (Dave Hart) and the Behavioral Health Court Judge (Jennifer Morse) were interviewed as key informants.

In May, 2016 we had two stakeholder meetings that focused on the new Prevention & Early Intervention regulations. There were a total of 29 participants, which represented a range of stakeholders, including consumers, family members and providers. On September 13, 2016, we had a Town Hall meeting to discuss and get input on MHSA, as well as inform the public on State regulations that will be affecting the funding. We included a discussion on our innovative projects. All of these meetings were announced via emails and announcements in the local newspapers. Fifty-six persons sign in, and a few others declined to sign in. The group represented community service providers, such as MHCAN, Community Connection, Encompass, Pajaro Valley Prevention & Student Assistance, Applied Survey Research, County Office of Education, NAMI, Front Street, and the County. There was also a large presence of clients/consumers.

Learning Objectives and Evaluation:
Santa Cruz County Mental Health & Substance Abuse Services will work with Applied Survey Research (ASR), an independent evaluator, to evaluate the implementation and impact the Integrated Health Supportive Housing (IHHS) program. Upon funding, ASR will be contracted to develop and submit a fully articulated evaluation plan for review and approval. Like the intervention itself, the evaluation will follow a participatory approach in which representatives of key program stakeholder groups will be asked to provide input on fundamental aspects of the evaluation such as stating primary and secondary evaluation questions, selection of new measures, creation of data collection/management procedures, problem solving emerging challenges, interpretation of findings, reporting, and making data-based recommendations.

The evaluation will include a focus on the formative questions posed earlier in the proposal: (1) Is there an improvement in health measures in areas of diabetes, hypertension, COPD and obesity. (2) Are consumers with co-occurring mental health and other health conditions able to live successfully in independent housing in the community? (3) Is there an increase in consumer socialization and community engagement? (4) Is there an improvement in consumer satisfaction with their living situation? Information gathered to answer these questions will be used to iteratively improve the model. Data collection methods and sources may include questionnaires, interviews, and clinical records. Baseline data collection will occur during the first year of funding with a cohort of the population.

Because the purpose of the evaluation is to provide generalizable knowledge for the state of California, the study would be considered research and its research protocol would be subject to review and oversight by ASR's federally approved Institutional Review Board (IRB) for the protection of human subjects. ASR would be responsible for leading the development and submission of the research protocol for IRB review, including consent procedures. ASR will work closely with County staff to

delineate study recruitment, enrollment, and data collection responsibilities and will coordinate with analysts to obtain de-identified clinical records if these are included in the final evaluation plan.

The Budget:
The proposed budget includes non-recurring costs of Telehealth Devices and Telehealth Integration Fees, Personnel costs (for Medical Assistant), Contractor Integrated Health Housing Support Team, Master Lease and Rent Subsidies, and Program Evaluation.

Additional Regulatory Requirements:
The proposed INN project reflects and is consistent with the MHSA General standards. The primary purpose of this project is to increase the quality of mental health services, including measurable outcomes.

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AGENDA ITEM 3

Action

February 23, 2017 Commission Meeting

Merced County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Merced County's request to fund a new Innovative project: Innovative Strategist Network (ISN) for a total of $6,862,288 in Innovation component funding over five (5) years. Merced County proposes to introduce a new a system wide change to the mental health services delivery process, by hiring a network of strategist with an innovative thought pattern that will implement the model and begin bridging the gap and opening the pathway to underserved individuals.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

The ISN project proposes to hire a team of innovative strategist that consists of 1.0 FTE BHRS Program Manager, 1.0 FTE Psychiatric Staff Nurse, 1.0 FTE Mental Health Clinician, 2.0 FTE Mental Health Worker, 1.0 FTE Quality Assurance Specialist, 1.0 FTE Family/Community Development Partner, and 0.625 FTE Extra-Help Consumer Assistance who will implement the ABC model with hopes to transform the current system of healthcare in Merced County. The INN project does not fully comply with the minimum Innovation regulations given it is unclear what the evaluation plan is and the specific budget dedicated for evaluation.

Presenter:

- Sharon A. Jones, MHSA Coordinator, Merced County

Enclosures (3): (1) Staff Commission Meeting INN Regulatory Handout; (2) Staff Innovation Summary, Innovative Strategist Network (ISN); (3) Merced County Innovation Brief.

Handout (1): PowerPoint Presentation.

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

http://mhsoac.ca.gov/document/2017-02/merced-county-inn-project-innovative-strategist-network-isn

Proposed Motion: The MHSOAC approves Merced County's Innovation Project, as follows:

Name: Innovative Strategist Network (ISN)

Amount: $6,862,288

Project Length: Five (5) Years

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Innovation Regulatory Handout

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

Staff Summary Analysis Includes:

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

STAFF INNOVATION SUMMARY— MERCED COUNTY

Name of Innovation (INN) Project: Innovative Strategist Network (ISN)

Total INN Funding Requested for Project: $6,862,288

Duration of Innovation Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: November 22, 2016

County Submitted INN Project: November 29, 2016

MHSOAC Consideration of INN Project: February 23, 2017

Project Introduction:

Merced County proposes to introduce a new system to the mental health care service delivery process that plans to integrate and build on the principles of three (3) models currently being used in healthcare, (A) Appreciative Inquiry, (B) Building Capacity, and (C) Care Coordination. The County has coined combination of these three models as the "ABC Innovative Framework Model", and they expect to utilize this model to create a big change in their community. The County plans to provide barrier-free services with the adoption of this model, allowing clients to be given exactly what they need through an open, whole person care, and more customizable version of mental health services delivery. The model will be implemented by the Innovative Strategist Network (ISN) staffed by newly hired strategists responsible for a specific area of expertise. The ISN will consist of a Lead Strategist, Intergrated Care Strategist, Behavioral Health Strategist, Care Coordination Strategist, Family/Resource Strategist, Recovery Strategist, Program Support Strategist, and Youth-Specific Strategist. The County states the ISN will be dedicated to coordinating care and providing linkages throughout the system of care with the intention of improving Merced County's mental health services delivery process.

In the balance of this brief, we address specific criteria that the OAC looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the OAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or

locally adapted mental health approach/practice, and targets one of the four, allowable, primary purposes.

The Need

Merced County states it is a medium-sized, rural county with a shortage of primary care doctors and mental health professionals and designated as a Health Professional Shortage Area (HPSA). The County also states the University of Wisconsin's Population Health Institute, School of Medicine and Public Health ranked Merced County 43rd out of 59 California counties on Primary Care Physician (PCP) to patient ratio, with 2,334 residents for every PCP. Merced also states the 2015 Community Needs Assessment report indicated 20.5% of the adults in the County were limited in their lives due to physical, mental, or emotional issues. Merced states their current system consists of the Medi-Cal plan, Central California Alliance for Health non-profit health plan, and contracted services through Beacon Health Strategies. While Merced County states their mental health system has been enhanced by the implementation of MHSA in 2006, they lack a dedicated unit to coordinate care and provide linkages throughout the systems of care and the need for systemwide transformational network change. The County can benefit from expanding on how MHSA and other health plans mentioned above have not been able to create more structure and less fragmented health care system with the capacity to support the County's needs.

The Response

The County has taken three concepts, used by others to improve the mental health service delivery system and other industries, and infused them into a new concept named by the County as "**ABC** Innovative Framework Model". The model brings together the following three concepts. The County may wish to expand on the reason to combine these three concepts and how the community planning process was involved in selecting them for the Innovative Project.

- **A**ppreciative inquiry- provides an alternative approach to the inquisitional style of uncovering "what went wrong and who is at fault" to instead build off of "what has been going well" and "what can be done to make things better," thus creating an environment that enables one to "discover, dream, design, and deliver/ destiny", which is what the County is calling the 4-D cycle approach.

- **B**uilding Capacity (also known as capacity building)- a conceptual approach to social or personal development that focuses on understanding the obstacles that inhibit people, governments, international organizations and non-governmental organizations from realizing their development goals while enhancing the abilities that will allow them to achieve measurable and sustainable results. The model has been used in the mental health arena in one example on a global scale.

  In recent international mental health research projects, the use of building capacity has been tested to determine how mental health interventions have been adapted for use across cultures and in low resource environments, in countries such as, Sri Lanka, Burundi, Indonesia, Sudan, Cambodia, Uganda, Zambia, Tanzania,

Pakistan, Iraq, Nepal, and Thailand. Evidence continues to cumulate for the need to determine the feasibility and effectiveness of certain, specific interventions and how to train, supervise, and ideally sustain mental health treatment delivery by local providers in low- and middle-income countries. Task shifting, employed in all these studies, involves moving the primary provision of the mental health intervention from mental health specialists (e.g., psychiatrists, psychologists, Master level providers) to lay counselors (i.e., limited to no mental health training or experience). This approach is responsive to the reality that addressing the mental health services gap requires an emphasis on a lay counselor workforce. Merced County may wish to expand upon how their approach will differ from other mental health systems looking at alternatives to build their capacity to serve the mental health needs of their constituents.

- **C**are coordination- according to Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.

The County intends to hire an Innovative Strategist Network team consisting of seven (7) staff to implement their new ISN model. The County plans to hire the following positions: Lead Strategist, Integrated Care Strategist, Behavioral Health Strategist, Care Coordination Strategist, Family/Resource Strategist, Recovery Strategist, Program Support Strategist, and a Youth-Specific Strategist. The Youth-Specific Strategist will be a non-County position and will be selected through an RFP process. According to the County this team will provide the linkage to services that clients are missing with the current system of care. The County may wish to explore how hiring these particularly staff will support the ABC Innovative Framework Network and how they will be trained on the concepts.

The County agrees many aspects of role and function of the Innovative Strategist Network team is similar to services provided under the Full Services Partnership component of MHSA. The Merced Community Assistance Recovery Enterprise (CARE) program has provided comprehensive mental health services to the underserved in Merced County since 2006. The CARE Program is one of the county's two FSPs available and are limited to a maximum number of participants (70). Ultimately, the county hopes this model will be able to serve more than the 70 individuals currently being servied by the FSPs. The County is not sure how many individuals will be affected by the Innovative Project given they do not have a true baseline of the need for the County. They may wish to provide futher clarification on how this Innovative Project is proposed under Innovations instead of Community Services and Support.

Unfortunately, it is unclear exactly how the services will be provided during the roll out of the ISN. Further, it is unclear how the current system of care is failing such high numbers of individuals in Merced County. The County has not been able to establish an accurate

baseline of the “need”. The County may wish to further clarify how their project is related directly to the mental health needs of their clients and to measure the impact of the project on the “gap” in services. It is also unclear how the County will support the individuals who are not linked to services. The County may wish to elaborate on these items.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the county presents meeting this requirement.

Merced County indicated that this project was developed with community input over a 15-month period and overseen by the MHSA Ongoing Planning Counsil, which is made up of community stakeholders in the County. The County states their CPP included a total of 92 participants, majority of which were community members and mental health providers. This project was approved by the Merced County Board of Supervisors on November 22, 2016, after completing the 30-day Public Comment and Review. It is not clear if the County engaged with other industries or organizations who used appreciative inquiry, capacity building, or care coordination to determine how best to incorporate these concepts into their Innovative project.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the INN Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the INN’s primary purpose, (d) how the County will assess which elements of the INN contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

The County has proposed their five-year Innovative project will focusing on learning the following:

1) How does the design of an Innovative Strategist Network, with the focus on strength based strategies to open pathways to wellness, impact improved access to services and linkages to other providers?

2) How will developing an “ABC Innovative Framework Model”, inclusive of the 4D-Cycle approach, impact positive client outcomes and stigma reduction?

3) How does the development of a professional and knowledgable Strategic/Innovative team build community capacity and care coordination?

4) How does this Innovation Project increase the number of adults being served and provided adequate resources and services?

5) Does the Innovation Project impact adults desiring improvements in their mental health and wellness by identifying resources and connections to appropriate care?

The County expects their outcomes will be the common philosophy and approach to mental health service delivery in Merced County. The County states they will obtain their data from demographic sheets, quarterly participation surveys, client satisfaction surveys, and use of asset mapping. The County will also collect basic data (e.g., participation, number of served , tracking service providers, etc.), in the hopes of identifying improvement or deficits during the systematic change. This seems necessary given the County does not have baseline numbers to best determine the actual need for this Innovative project and appears to be using the Innovative project timeline and funds to accurately assess for this gap in services.

In the event that this proposed project is successful, Merced states the project will provide a new framework and methodology for serving the Merced County communities. This framework will develop a better expertise on how to make referrals. The County wants the result to be an effective network of proactive community providers to refer clients to the Innovative Strategist Network.

It is unclear to the staff of how the learning objectives will be accomplished, and how this project will be measured for outcomes. There is also a question as to how this plan will continue after the 5 year project has expired and what funding source the County intends to use to sustain the program and provide the services during the Innovative project given new individuals will be referred to services and the County states they have a shortage of workforce to support the project's capacity.

The Budget

This section addresses the County's budgeting for the scope of their project, the length, and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The Innovation funds budgeted for this project is $6,862,288 over a timeframe of five (5) years, dispersed over an initial six-month budget, four year-long budgets, and a final six-month budget. The five-year budget allocates $4,677,999 of Innovation Funds, approximately 68%, to hire 7.625 positions to implement the new model:

BHRS Program Manager	1.0 FTE
Psychiatric Staff Nurse	1.0 FTE
Mental Health Clinician	1.0 FTE
Mental Health Worker	2.0 FTE
Quality Assurance Specialist	1.0 FTE
Family/Community Development Partner	1.0 FTE
Extra-Help Consumer Assistance	0.625 FTE

Additionally, the five-year budget allocates $189,200 for operating costs and $1,100,000 for contracted cost to handle the RFP process for only the hiring of the "TAY Strategist" who will support the TAY services of the County. It is unclear how the budget matches

the role and function of this one position. The remaining balance of $895,080 is to cover the total administrative costs for the County staffing. There is no budget set aside for evaluation, which is a part of the Innovation regulations.

Additional Regulatory Requirements

The proposed project does not appear to meet the minimum standards for compliance for requirements of the MHSA Innovation Plan and its regulation given there is no specific budget or clear plan for evaluation. The County may also wish to expand upon the areas of further clarification requested in this staff summary.

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BEHAVIORAL HEALTH AND RECOVERY SERVICES (BHRS)
MHSOAC BRIEFING

INTRODUCTION

Merced County seeks approval for one Innovative project. The project is referred to as the ABC Innovative Framework Model through the implementation of an Innovative Strategist Network (ISN). The project is designed for transformational benefits; community-wide innovative thinking, strategies and actions to increase improved mental health outcomes and services.

NEED

Many programs are giving life in Merced County however, due to the many social determinants of health there is the need for an improved infrastructure. Merced County has a population that continues to grow the Central California Alliance reports that there are over 120,000 Medi-Cal beneficiaries and according to the July 2015 US Census the total population is 268,455.

Merced County is a 100% professional shortage area (HPSA) and ranks 43rd out of 59 counties on Primary Care to Physician ratio 2,334 residents for each PCP. The cost of depression (including direct medical costs as well as absenteeism from work or school) in Merced County is estimated to be $49,939,206.00 annually. Also, 20.5% of Merced County adults are limited in some way or in some activities due to a physical, mental or emotional problem. At this time, there is an insufficient system flow, absence of infrastructure, shortage of capacity to provide services, the need for strategic goals and system-wide improvement and sustainable effort. In Merced County there are many programs that have specific rules and guidelines which may keep the person from getting the care they need depending on their situation. The ABC Innovative Model would be implemented by strategists that are diverse in their perspectives having varied worldviews, lived experiences and approaches.

The primary purpose of the project is to develop an ABC Innovative Model Framework through an innovative Strategists Network to address the issues of access to services and interagency collaboration for those living with severe mental illness and those in need of mild to moderate care. This model includes: hiring an innovative strategist team, utilizing strategies of appreciative inquiry, building capacity, care coordination and putting into place an evaluation process to measure the success.

RESPONSE

The primary purpose of the project is to develop an ABC Innovative Model Framework through an innovative Strategists Network to address the issues of access to services and interagency collaboration for those living with severe mental illness and those in need of mild to moderate care. This model includes: hiring an innovative strategist team, utilizing strategies of appreciative inquiry, building capacity, and care coordination. The need will be addressed by identifying a culturally responsive team (ISN) to take the lead to build a transformational culture that supports positive

mental health outcomes and services. The ABC Framework Innovative Model/ISN came to be through the MHSA Community Planning Process which included community meetings, focus groups and key informant interviews. This is an active stakeholder process which is connected to the MHSA Ongoing Planning Council which meets each month. Stakeholders acknowledged that there is a need to build a system of unique innovative and relevant strategies and leverage existing resources and collaborations to meet the mental healthcare needs of those living in Merced County. The ABC Framework will provide a model to address barriers, closed pathways and the need for community wide innovation and support so that every member can have their own voice, in their own form, and choose their own healthcare goals. This project is highlighting Innovation as a pulse for community change, mental health care and quality improvement. Presently, there are many agencies and programs making transactional steps to make improvements where the climate is just being managed. In order to address the requests of the community stakeholders there has to be a focus on changing the culture this is transformational change. The three selected approaches appreciative inquiry, building capacity and care coordination were selected because the stakeholders believe the spark is already there so the goal is to build a model to further strengthen efforts combining all three concepts. Most of the programs are operating from rigid, specific and narrow protocol. The ABC Innovative Framework is to open the lens wider to provide a pathway to needed care and to change the conversation in Merced to Hope. Merced County will test out a different approach than other mental health systems looking at alternatives to build their capacity to serve the mental health needs. Individuals in need will have the opportunity to select from seven strategists to improve their health outcomes. The goal is that the stigma will be reduced by offering more than one strategist.

INNOVATION

Merced County will apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings. The Merced Community will develop and test out the ABC Innovative Framework Model which will be adapted from successful practices in Leadership Development, Change Management and Capacity Development field of expertise. The model will combine Appreciative Inquiry, Building Capacity and Care Coordination as transformational change agents through the utilization of an Innovative Strategist Network. The ISN will consist of a Lead Strategist, Integrated Care Strategist, Behavioral Health Strategist, Care Coordination Strategist, Family/Resource Strategist, Recovery Strategist, Program Support Strategist, and Youth-Specific Strategist. The ISN will be trained in this ABC Innovative Framework Model. This will be a new developed model that has never been used in mental health settings.

EVALUATION

In the initial startup phase of the project the an internal evaluation team will be assigned and will consist of Staff Service Analysts and Quality Assurance Specialist from the areas of Quality Improvement, MHSA, and Automation Services. Also, included will be members of Leadership, MHSA Planning Council, and the Innovative Strategist Team. There will also be included an External evaluator to work with the internal evaluation team. The evaluation and implementation team will evaluate the effectiveness of the ABC Innovative Framework/ISN.

BHRS Staff Analyst Team will be responsible for developing and evaluation plan to address outcome measures along with an external evaluator.

BHRS will develop an evaluation framework to address the effectiveness of the ISN, including consideration of the identified learning objectives and evaluation of community, system and client

level outcome measures, including, but not limited to, data reports, development and tracking of program goals, satisfaction surveys and measurement tools.

ISN Project evaluation will be a multi-year process and stakeholders will be updated and have input along the way

Progress and outcomes will be communicated to the community through presentations and updates at MHSA Ongoing Planning Council meetings, community partner meetings, Behavioral Health Board meetings and special learning conferences.

BUDGET

Budgeting and Time Period
Proposed 5-Year Implementation Period
Adult ISN funding total: $5,597,288 (BHRS)
Youth ISN funding total: $1,265,000 (Contracted)
TOTAL 5-YEAR FUNDING: $6,862,288

Other funding sources will be leveraged for evaluation support and training staff development.

AGENDA ITEM 4

Action

February 23, 2017 Commission Meeting

Riverside County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Riverside County's request to fund a new Innovative project: Commercially Sexually Exploited Children (CSEC) Mobile Response for a total of $6,252,476 in Innovation component funding over five (5) years. Riverside County proposes to increase the quality of mental health services by creating four multidisciplinary mobile teams to rapidly respond and provide well-supported best practices for CSEC and their families or caregivers.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

The CSEC Mobile Response project proposes to hire four response teams consisting of: 1.0 FTE Clinical Therapist, 1.0 FTE Transition-Age Youth Peer Advocate/Survivor, 1.0 FTE Parent Partner, 1.0 FTE Office Assistant, 0.25 FTE Mental Health Services Supervisor, 0.25 FTE Behavioral Health Specialist, 0.25 FTE Licensed Vocational Nurse, and 0.25 FTE Staff Psychiatrist. The team will provide a well-supported therapy for complex trauma adapted with a well-supported treatment to motivate and engage this CSEC population to seek and stay in mental health services, along with medication services, peer support, and case management services. The INN project complies with all MHSA requirements as indicated in the regulations.

Presenters:

- Paul Thompson, Deputy Director, Children Services
- Diane Mitzenmacher, Supervisor Children Treatment Services

- Suzanna Juarez-Williamson, Supervising Research Specialist
- Paul Gonzales, Administrative Services Officer, Fiscal
- Bill Brenneman, Deputy Director, Adult Services and Acting MHSA Administrator

Enclosures (2): (1) Staff Commission Meeting INN Regulatory Handout; (2) Staff Innovation Summary, Commercially Sexually Exploited Children (CSEC) Mobile Response; (3) Riverside County Innovation Brief.

Handout (1): PowerPoint Presentation

Additional Materials (1): A link to the County's complete Innovation Plan is available on the MHSOAC website at the following URL: http://mhsoac.ca.gov/document/2017-02/riverside-county-inn-plan-commercially-sexually-exploited-children-csec

Proposed Motion: The MHSOAC approves Riverside County's Innovation Project, as follows:

Name: Commercially Sexually Exploited Children (CSEC) Mobile Response

Amount: $6,252,476

Project Length: Five (5) Years

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Innovation Regulatory Handout

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

Staff Summary Analysis Includes:

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY—RIVERSIDE COUNTY

Name of Innovative (INN) Project: Commercially Sexually Exploited Children Mobile Response

Total INN Funding Requested for Project: $6,252,476

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: Not Submitted

County Submitted Innovation (INN) Project: December 28, 2016

MHSOAC Consideration of INN Project: February 23, 2017

Project Introduction:

Riverside County proposes to improve the quality of services for child victims of commercial sexual exploitation through a Commercially Sexually Exploited Children (CSEC) Field Response Project. It will create four multidisciplinary mobile teams to rapidly respond and provide well-supported best practices for CSEC and their families or caregivers. The team will provide a well-supported therapy for complex trauma adapted with a well-supported treatment to motivate and engage CSEC to seek and stay in mental health services, along with medication services, peer support, and case management services.

In the balance of this brief we address specific criteria that the OAC looks for when evaluating Innovation Plans, including: What is the unmet need that the County is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the County to make any conclusions regarding their learning objectives? In addition, the OAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

Riverside County states Los Angeles and San Diego metropolitan regions are rated as two of the thirteen "high intensity child prostitution areas" in the US, with the Inland Empire (a prominent section of Riverside County just east of Los Angeles) as a location for known for its own "hot spots" for human trafficking. Riverside County's Department of Probation and Public Social Services identified 129 CSEC and have studies estimating between 50% and 80% of victims of commercial exploitation are or were known to the child welfare department. This range reflects the barriers many counties face in accurately determining the total CSEC population due to a general lack of understanding of CSEC and inability to identify the victims. As a result, Riverside County has developed the Committee Against the Commercial Sexual Exploitation of Children to address the problem through improving interagency collaboration, developing tactics to better identify the victims, and increasing knowledge of trauma-informed care among services providers. The County states while education and identification is improving, determining the most effective mental health service model for CSEC victims remains unclear. The County states they want to expand the research beyond the current focus on the legal aspects of human traffickers to one determining the best practice to help the CSEC victims recover and transition into productive and future oriented lives.

The Response

It appears Riverside County's Innovation project is combining many different best practices demonstrated to be effective into one comprehensive treatment approach. The County proposes that creating four field-based wraparound service teams, encompassing a trauma-informed care approach with a peer and family component and providing an adaption of a trauma-specific intervention, will improve the engagement, retention, and outcomes for CSEC. The County may wish to provide more information about how they foresee combining the best practices below will bring forth new information on addressing the multifaceted and complex needs of CSEC.

There has been increasing focus on treating the specific mental health needs of the complex trauma experienced by CSEC, with counties such as Los Angeles, San Diego, San Francisco, Riverside and Alameda developing task forces, training programs, and comprehensive service models to address this issue. While current efforts are improving the identification of CSEC, other projects and research reviewed by OAC staff indicates the complexity of the abuse and trauma CSEC endure plays a significant role in preventing victims to seek out and maintain mental health service participation for successful outcomes. CSEC present with similar barriers to treatment and unmet needs as seen in individuals needing mental health services for addiction, intimate partner violence, history of sexual abuse or sexual trauma, or other life experiences leading to Post-Traumatic Stress Disorder (PTSD). Like those living with addiction or in intimate partner violence relationships, CSEC struggle to accept the need to change the "problematic" behavior despite numerous interventions or indications the change is warranted. CSEC also need more support in developing trust and establishing a sense of safety similarly seen in individuals with a history of sexual abuse, sexual trauma, or PTSD. Then when the individual finally decides to seek treatment for these issues, sustaining

treatment poses a challenge given the lack of motivation to stay or inability to tolerate the difficulty behind effective trauma treatment.

Based on research conducted by OAC staff, it appears Riverside's project intends to address the two abovementioned issues for CSEC. Riverside County is encouraged to further clarify their rationale for choosing the following combination of best practices they outline in their proposal. Research shows how TF-CBT is effective in treating the mental health needs of CSEC given it directly addresses the impact trauma has on their life to facilitate recovery for those who stay in treatment and why many have implemented this model throughout the State and nation. The key component of TF-CBT is the child describing their personal traumatic experiences in a "trauma narration" which is shared by the child to the parent/caregiver in a trusted and supportive matter. This can be a difficult "ask" for any child (requesting them to re-experience a trauma repeatedly until they can accept the life event with little or no distress), and in particular CSEC who may have limited trust in authority figures or caretakers. This may explain the challenge Riverside County and other counties have in getting CSEC to even agree to treatment, start the difficult trauma work and stay in treatment to heal and be empowered.

Riverside is encouraged to discuss the reason they are adapting the evidence-based practice (EBP) TF-CBT to include Motivational Interviewing (MI) and which staff on their CSEC team will be providing the various components of the adapted EBP. Further clarification can be made on what impact the County is seeking by having certain staff trained to provide either TF-CBT or MI, specifically a TAY Peer Specialist with lived experience and a Parent Partner. MI is traditionally used to support individuals with addiction to increase their motivation to change a behavior. MI also proves to be effective with highly resistant populations to initiate and sustain effective treatment and can be offered by any member of a multi-disciplinary team, while TF-CBT is a best practice only offered by a trained clinical therapist. Therefore, many populations who benefit from peer-support, such as addiction and intimate partner violence treatment, train people with lived experience to provide MI to motivate individuals to change a "problematic behavior". It is unclear how having a Parent Partner will play a role with supporting the needs of CSEC who are living in a group home, living on the streets, in a crisis shelter, or moving between many foster homes.

The County is also encouraged to clarify how implementing a well-established systematic trauma informed care approach will differ from their previous interagency collaborative work for CSEC. Riverside may wish to connect the core principles of trauma-informed care (including promoting safety, sharing power and governance, and supporting the individual's control and autonomy) to their Innovative project strategies.

Riverside seems to be constructing their field based wraparound service team on "Coordinated Specialty Care", which according to the National Institute of Mental Health, is a general term used to describe a recovery-oriented treatment program for individuals with first episode psychosis. It includes a set of specialists providing psychotherapy, medication management, family education and support, and case management with smaller caseloads of 25-30 clients or less, frequent team meetings, central point of referral with staff dedicated to outreach and referral, coordinated entry to the program,

and working as a team in a shared decision-making framework. This team approach is also similar to how many counties implemented Assertive Community Treatment (ACT) and MHSA Full-Service Partnership (FSP) teams and Riverside may wish to clarify how their Innovative project differs.

Riverside states they want to build on lessons learned from implementing at least four best practices for trauma in children and TAY through their previous Prevention and Early Intervention (PEI) plans. They may wish to provide clarification what lessons they still need to learn and how this Innovation project will facilitate the learning.

OAC staff have identifying programs targeting similar populations and needs. Links for these programs are available in the Reference section of the summary. Riverside may wish to clarify how their project differs from these programs.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the county presents meeting this requirement.

The County prioritized this Innovation program based on input and feedback from multiple entities and stakeholders in Riverside County that struggle to meet the needs of exploited children in their area. The County's stakeholders include: MHSA System of Care planning committees, the Behavioral Health Commission, Riverside County Anti-Human Trafficking Task Force (RCAHT), Committee Against the Commercial Sexual Exploitation of Children, Riverside County Child Assessment Team, school districts, Parent Partners, Department of Public Social Services, law enforcement, District Attorney's office, and Riverside County TAY Collaborative. The stakeholders indicated challenges with identifying and tracking the coordination of mental health care to youth and understanding the mental health needs of CSEC. The planning process seems weighted towards agencies and it is unclear how many of the agencies listed may have worked with consumers and family members in their planning process. The County may wish to provide further clarity on how they included consumers and families in the planning process.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

The County states the CSEC Field Response Project will test if an adapted evidence

based practice (TF-CBT) delivered within a coordinated Specialty Care model will improve outcomes for CSEC.

The County states the project will focus on two learning objectives:

1. The effectiveness of adapting TF-CBT with MI CSEC to understand if an adapted approach delivered in a coordinated Specialty Care Team model increases engagement, retention, and outcomes.
2. The effectiveness including the use of TAY Peer Specialist and Parent Partners to increase engagement and retention in services and improve outcomes.

The primary data source for evaluation and analysis will be electronic health records of the consumers and surveys for consumers, families, peer support staff, and clinical staff. The County states they intend to also use clinical measures to determine the effectiveness of an adapted EBP. The County may wish to provide more information about the target population including how 129 victims had been identified by the County but they intend to target only 100 CSEC youth annually.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The estimated Innovations budget total for this project is $6,252,476 over the five (5) year proposed duration. The total cost of the project is $17,229,274, with funds from Federal Financial Participation, and the Behavioral Health Subaccount. The County provided a budget narrative and detail about the overall projected expenditures and other funding sources and is encouraged to offer specific details on the listed deliverables' relation to the Innovative project.

The budget allocates $2,333,829 of Innovation Funds, approximately 37%, to hire four (4) Field Response Project Innovation teams. Each team will be comprised of:

Clinical Therapist	1.0 FTE
Mental Health Peer Specialist	2.0 FTE
Behavioral Health Specialist	.25 FTE
Licensed Vocational Nurse	.25 FTE
Mental Health Services Supervisor	.25 FTE
Staff Psychiatrist	.25 FTE
Office Assistant	1.0 FTE

It is not clear if the 2.0 Mental Health Peer Specialists is for the TAY Peer Specialist and the Parent Partner.

The budget allocates $1,150,068, 18% of Innovation Funds, for operating costs, including

$4,854 for building and rental expenses. The budget allots $767,200, 12% of Innovation Funds, non-recurring costs, including $200,000 for vehicles and office equipment. The County budgets $18,671 for consultant costs, contracts, and program evaluation, which is 0.2% of Innovation Funds. It appears the County intends to use non-Innovation funds to cover majority of the evaluation budget. Lastly, the budget allocates $1,982,709, 31% of Innovation Funds, for "flex funding" and program administration costs. Riverside County may wish to provide further clarification under operating cost and what "flex funding" entails.

The County states services will continue with funding from Medi-Cal and Community Services and Supports funds if the program results in successful outcomes.

Additional Regulatory Requirements

Commission staff finds the County proposal has met minimum regulatory requirements, and Riverside County may wish to provide further clarification on their Innovation project budget. The proposal would benefit from more information about the role of the TAY Peer Specialist and Parent Partner. The proposal outlines a Field Response Project that will respond to requests for services in the community directly but limited information has been provided on this component and further clarification is encouraged.

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Name of Project: Commercially Sexually Exploited Children (CSEC)
County: Riverside
Target Population: Commercially Sexually Exploited Children (CSEC)
Total Innovation Funding Request: $6.2 Million over 5 years
Duration: 5 Years

The Project

The proposed CSEC Innovation Project combines an adapted Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) model to effectively treat trauma with a field-based approach designed to meet challenges of engagement unique to this population. This CSEC project aims to test an adapted evidence-based practice (TF-CBT) to determine if the adaptation delivered within a coordinated specialty care team model will, as a whole, improve outcomes for this population. The key element of this Innovation Project involves adapting TF-CBT to utilize Motivational Interviewing within a team field-based service delivery approach including Transition Age Youth Peer survivors and Parent Partners to focus on engaging and supporting youth and families/caregivers. This Project is an opportunity to learn about effective ways to deliver mental health treatment that would meet the needs for this vulnerable and challenging population of youth. Having youth and family work with a single team across regional boundaries contributes to consistent relationships during the critical phase of engagement. This one child, one family, one team concept is highlighted by CSEC survivors and families as a key component of treatment.

The Need

The overwhelming majority of published literature on Commercially Sexually Exploited Children (CSEC) is focused on defining the scope of the problem and describing law enforcement and social services (housing, medical, and educational) needs with little to no information available on the best clinical mental health approaches for providing therapy services to youth victims. Despite the existing knowledge about the short- and long-term impacts of child sexual abuse, few treatment modalities for CSEC populations have been rooted in evidence-based practice (Lev-Wiesel 2008). It has been reported in the literature that these youth are challenging to engage in mental health treatment because the youth often do not view their exploitation as traumatic and want to return to the abuser. Dangerous and risky behavior, combined with repeatedly running away, also make it difficult to continue to provide treatment (Cohen, Mannarino, & Kinnish, 2015). Multiple problems can overwhelm caregivers and lead to challenges in providing stable placement (Cohen, Mannarino, & Kinnish, 2015). Researchers have recently suggested that adaptations to evidence-based treatments are needed to address the complex clinical needs of these youth (Cohen, Mannarino, & Kinnish, 2015). Specific therapies which may help reduce trauma symptoms related to CSEC have not been tested and little is known about their effectiveness. Additionally, there is little information regarding engagement of CSEC victims and their families into care and their successful return to the community.

Data on the specific trauma therapy and outcomes with this population are not available. A review of over thirty articles and internet sources showed evidence-based data on mental health treatment for child sex trafficking victims is lacking. A number of articles focused on the scope of the problem, characteristics of the population and methods to identify youth at risk of trafficking with little to no literature or data on the best approaches for mental health

treatment. The Casey Foundation (2014) recently conducted a national survey to gather child welfare leader insights into the problem and identify what they needed to learn more about in order to combat it. The Casey Foundation report (2014) noted that the vast majority of respondents indicated that they wanted to know more about the best practices for treatment of child victims of sex trafficking.

The Response

The issue this Innovation Project addresses is the lack of knowledge regarding the model of mental health service delivery that is most effective for child victims of commercial sexual exploitation. TF-CBT, developed by Drs. Anthony Mannarino, Judith Cohen, and Esther Deblinger, is an evidence-based treatment that has been evaluated and refined to help treat trauma in youth and their non-offending parents or caregivers (Cohen et al, 2006). In a recent publication, TF-CBT developers noted the multiple clinical challenges that CSEC youth face and the need for information on using TF-CBT with adaptations for this population (Cohen et al, 2015). This adaptation involves integrating Motivational Interviewing (MI) and the stages of change model in order to optimize engagement and treatment completion of TF-CBT. MI was originally developed to increase engagement in substance abuse treatment, but is also used as an adjunct to treatments of other mental health problems for recalcitrant populations (Westra, Aviram, & Doell, 2011). Trained and experienced clinical therapists will provide TF-CBT. TAY Peers and Parent Partners will provide services to youth and families/caregivers to enhance engagement and provide support using MI. These TAY Peers and Parent Partners are an integral part of the CSEC Specialty Care Team working to identify and overcome barriers and support all phases of TF-CBT treatment.

The CSEC Field Response Project will establish four teams each with a Clinical Therapist, Parent Partner, a Peer Specialist (with transition age youth experience), a Licensed Vocational Nurse, and a shared Behavioral Health Specialist to provide a rapid response to request for services for a CSEC youth and their families or caregivers. These youth often runaway before the engagement process can begin, so a team response within a window of 48 hours is optimum. Consistent contact with a select number of team members during the engagement process will provide consistency for youth and families as therapeutic engagement develops. A field-based coordinated Specialty Care Team using a “Wraparound” like approach is best suited to address the challenges of the CSEC population. Utilizing strategies suggested by the developers of TF-CBT, these teams will be trained in using TF-CBT with an adaptation to include MI and significant work with caregivers to engage and treat CSEC youth (Cohen, Mannarino, & Kinnish, 2015).

Planning Process

Riverside University Health Systems-Behavioral Health (RUHS-BH) conducts an on-going continuous planning process year round. This includes eliciting feedback and informed decision making through subject matter experts that comprise the MHSA System of Care planning committees. MHSA staff also provide monthly updates to the Behavioral Health Commission as they act as an advisory body on all aspects of MHSA planning. The planning process includes key committees by age span. The Children's and Transition Age Youth Collaborative contributed to the planning process. There are several other cross-collaborative committees that advise the Department on certain specialty areas such as Criminal Justice, Cultural Competency/Ethnic Disparities, and the Consumer Wellness Coalition that lend ethnic-specific, consumer, and family member perspectives to the planning process. The participants involved

include mental health consumers, peer specialists, family advocates, parent partners, community-based organizations, and public agencies. Participants were representatives of underserved communities as well as persons serving those same communities. The MHSA Administrator and other RUHS-BH staff have been responsible for informing the various stakeholders regarding the purpose, scope, and limitations of Innovation Projects.

The decision to prioritize investigating methods to serve CSEC youth arose partly from the Department's aforementioned on-going planning structure and partly from the community committees and RUHS-BH task force participation. RUHS-BH participates in a task force, a committee, and a multi-disciplinary team (Riverside County Child Assessment Team) that all work to address the problem of commercially sexually exploited youth in Riverside County. The Riverside County Anti-Human Trafficking Task Force (RCAHT) brings together law enforcement, local treatment providers, and other experts.

RCAHT coordinates with the Federal Bureau of Investigations, the United States Attorney's office, and the Riverside District Attorney's office to protect sexually exploited youth, prosecute perpetrators, prevent commercial sexual exploitation, and partner with the community to promote awareness and understanding of the nature and scope of the problem. Attendees at RCAHT meetings include church leaders, concerned community members, youth serving agencies, and RUHS-BH. Topics in these meetings have included questions about what therapeutic responses are available to CSEC youth. Through participation in these groups, stakeholders reported a need for understanding the treatment options available and how to access them. Our stakeholders also indicated that they were challenged with identifying and tracking the coordination of mental health care to youth under their jurisdiction. School districts who participate in the CSEC committee also indicated a need to understand how to address the mental health needs of this unique population. RUHS-BH Parent Partners have heard from providers, youth, and families that there is a lack of understanding about where to turn for mental health services for sexually exploited youth.

Finally in the County TAY Collaborative the issue of what to do for commercially sexually exploited youth and how to address their trauma was identified by stakeholders as an area of need. The TAY Collaborative members include providers serving TAY across the county as well as TAY consumers of mental health services. The Collaborative reflects a diversity of ethnicities and geographic representation (Western, Mid-County, and Desert Regions). The TAY Collaborative has been a central vehicle for feedback from stakeholders in the planning and development process for MHSA projects. Partner agencies included in the TAY Collaborative include representation from the Riverside County Office of Education (RCOE), Special Education Local Plan Area (SELPA), Victor Community Support Systems (VCSS), Operation Safe House, Olive Crest, Recovery Innovations, STARS, Catholic Charities, Department of Public Social Services (DPSS), Public Health, and RUHS-BH Peer Support Specialists working with TAY and their families. The problem of how to address the treatment needs of commercially sexually exploited youth arose from these multiple stakeholder groups. This prompted RUHS-BH to investigate what was known about treatment and how RUHS-BH as a Department could respond.

Learning Objectives and Evaluation

The proposed CSEC Field Response Project will contribute new knowledge on the best service delivery approach for working with CSEC youth. It is expected that this project will contribute to knowledge on new methods to apply TF-CBT for special populations, and determine how to improve the practice by utilizing a service delivery approach that centers on a field-based coordinated Specialty Care Team with interagency collaboration. It is expected that this approach will result in increased engagement into care and retention as well as better outcomes for youth and families. The evaluation will focus on addressing the project's learning goals.

1. The project aims to assess the effectiveness of adapting TF-CBT for a commercially sexually exploited youth population to understand if this adapted approach delivered in a Specialty Care Team model increases engagement, retention, and outcomes. Because the adaptation is expected to have an impact on engagement and retention, data collection will include youth engagement and retention in services. This is an important indicator given that this population is known to have significant challenges with AWOL/running away and engagement into services. Mental health treatment outcomes are keenly related to maintaining the youth in therapy. Service data from the County electronic health record will be used to document participation in services, retention, and completion of mental health therapy.

   Further the outcome of TF-CBT services will be measured with pre to post data collection on trauma symptoms utilizing either the Trauma Symptom Checklist or the UCLA PTSD Index. General mental health functioning will be assessed pre to post with the Youth Outcomes Questionnaire. Symptom outcome measures will be directly collected by the CSEC Team staff.

2. This Innovation Project will assess the effectiveness of a coordinated Specialty Care Team approach with a CSEC Team including the use of TAY Peer Specialist and Parent Partners to increase engagement and retention in services and improve outcomes.

   CSEC youth and their families will be surveyed regarding their experiences with the CSEC Field Response Project. Additionally improvements in family/caregiver relationships will be assessed utilizing a structured interview approach. The survey on families' experiences and the structured interviews will be collected by the CSEC Team staff with the assistance of the RUHS-BH Evaluation Unit. Because the coordinated team will be focused on the overall well-being of the youth, functional outcomes will also be collected such as participation in school or work, reduced AWOL and placement challenges, and recidivism rates for youth returning to trafficking will also be measured.

A quasi-experimental approach will be utilized to assess the effectiveness of the CSEC Field Response Project. A treatment control group design is neither feasible nor ethical with this vulnerable population. Inferences on effectiveness will be drawn from the key data collected on engagement and retention into services, as well as outcomes on pre to post measures for trauma symptoms and general mental health functioning. Comparisons could be made to other published data on the engagement and retention of child sexual abuse victims in treatment or

youth in general in the County mental health system. However, as noted previously, there is no published data available on outcomes specific to the CSEC population.

It is expected that the CSEC Field Response Project Teams will do the primary data collection of the pre to post symptom measures as they will be working closely with the youth and family/caregiver. Some information on recidivism and placement statuses may be gathered from collaborative partners at probation and/or child welfare.

All data will be maintained and analyzed by the RUHS-BH Evaluation Unit. The Evaluation Unit expects to involve the TAY Peers and Parent Partners in the development of structured interview questions and CSEC experience survey items. This Innovation Project will benefit from input and feedback from a Senior Peer Specialist and other Peers and Parent Partners who are readily available in the Department's Research and Technology division, Consumer Affairs and Central Parent Support Units. Consultation with the Department's Cultural Competency Manager will support cultural competency of the evaluation. Reports will be drafted by the Evaluation Unit and reviewed with various stakeholders including program staff, TAY Peers, and Parent Partners for feedback and quality improvement learning opportunities.

References

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Cohen, J.A. Mannarino, A.P., Kinnish K., (2015). Trauma Focused Cognitive Behavioral Therapy for Commercially Sexually Exploited Youth. *Journal of Child and Adolescent Trauma*, December 28, 2015, Online First.

Westra HA, Aviram A, Doell FK. (2011). Extending motivational interviewing to the treatment of major mental health problems: current directions and evidence. *Canadian Journal of Psychiatry,* 56(11):643-50.

AGENDA ITEM 5

Action

February 23, 2017 Commission Meeting

Contract Authorization

Summary: The Commission has discussed the value of highlighting innovation as a strategy for transformational change. Commissioners also have expressed a need to create a broader, statewide discussion about priorities and opportunities associated with the MHSA Innovation Component. In support of those goals, the Commission will consider authorizing the Executive Director to enter into one or more contracts, not to exceed $350,000, to support events or activities relating to the MHSA Innovation Component.

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

Enclosures: None.

Handouts: None.

Proposed Motion: The Commission authorizes the Executive Director to enter into one or more contracts, not to exceed $350,000, to support events or activities relating to the MHSA Innovation Component.

AGENDA ITEM 6

Information

February 23, 2017 Commission Meeting

The Role of Innovation in the Healthcare and Mental Health Industry

Summary: Dr. Thomas Insel, M.D., will address the Commission regarding strategic opportunities to leverage Innovation component funding and projects, data, and performance metrics to drive transformational change in health and mental health care to improve public outcomes.

Presenter: Dr. Thomas R. Insel, M.D., Director, Clinical Neurosciences, Verily Life Sciences/Google

Enclosures (2): (1) Brief biography for Dr. Insel; (2) Letter from Toby Ewing, Executive Director, to Dr. Insel inviting him to present before the Commission.

Handout (1): A PowerPoint Presentation will be distributed at the meeting.

Mental Health Services
Oversight & Accountability Commission

Thomas R. Insel, M.D.

Thomas R. Insel, M.D., a neuroscientist and psychiatrist, leads the Mental Health Team at Verily (formerly Google Life Sciences) in South San Francisco, CA. From 2002-2015, Dr. Insel served as Director of the National Institute of Mental Health (NIMH), the component of the National Institutes of Health (NIH) committed to research on mental disorders. In that role he also served as Chair of the Interagency Autism Coordinating Committee (IACC) as well as co-lead of the NIH BRAIN Initiative. Prior to serving as NIMH Director, Dr. Insel was Professor of Psychiatry at Emory University where he was founding director of the Center for Behavioral Neuroscience and director of the Yerkes Regional Primate Center in Atlanta. Dr. Insel's research has examined the neural basis of complex social behaviors, including maternal care and attachment. A member of the National Academy of Medicine, he has received numerous national and international awards and served in several leadership roles at NIH.

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS · RECOVERY · RESILIENCE

February 9, 2017

Thomas Insel, M.D.
Director, Clinical Neurosciences
Verily Life Sciences
269 East Grand Avenue
South San Francisco, CA 94080

Dear Dr. Insel:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, February 23, 2017, in the Steinberg Room (1325 J Street, Suite 1700, Sacramento, California). This invitation stems from your informative discussion last week at Verily on opportunities to leverage innovation, data, and performance metrics to drive change in health and mental health care and improve public outcomes. Your participation will assist the Commission in framing the role of Innovation and evaluation for California's community mental health system.

Your presentation is scheduled for 1:30 p.m. Please plan on presenting for approximately 20-30 minutes, plus time for discussion with Commissioners.

If possible, we ask that you send a brief biography and any written testimony or other materials you wish to share in advance with Commissioners by Wednesday, February 15, 2017 to Urmi N. Patel, PsyD (urmi.patel@mhsoac.ca.gov). This will allow those Commissioners attending the meeting the opportunity to best engage with you during and after your prepared remarks.

We also ask that you please send Dr. Patel any presentation materials or handouts (e.g., a Power Point presentation) by Tuesday, February 21, 2017 so that we can prepare copies for distribution.

Please do not hesitate to contact me at (916) 445-8729 or toby.ewing@mhsoac.ca.gov or Dr. Patel if you have any additional questions. Thank you again for your willingness to participate in this discussion.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

AGENDA ITEM 7

Information

February 23, 2017 Commission Meeting

Executive Director Report

Summary: Executive Director Toby Ewing will report on projects underway, the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) calendar, and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures: None

Handout: None

Recommended Action: Information item only