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Commission Packet

Commission Meeting
April 27, 2017

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

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

April 27, 2017
9:00 A.M. – 2:45 P.M.
Sacramento County Office of Education
David P. Meaney Education Center, Board Room
10474 Mather Blvd., Mather, CA 95655

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.

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

Tina Wooton Chair	**AGENDA** **April 27, 2017**	**John Boyd, Psy.D.** Vice Chair

9:00 AM **Convene**
Chair Tina Wooton will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

9:05 AM **Welcome**

9:10 AM **Announcements**

9:15 AM **Action**
1: Approve March 23, 2017, MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the March 23, 2017 MHSOAC meeting.

- Public Comment
- Vote

9:20 AM **Action**
2: Senate Bills (SB) 191 and 192 (Beall)
Presenter: Carla Saporta, Legislative Consultant, Senator Beall's Office

The Commission will consider supporting two bills: SB 191 (Beall)- Student Mental Health and Substance Use Disorder Services; and SB 192 (Beall)- Mental Health Services Act Reversion Fund.

- Public Comment
- Vote

9:50 AM **Action**
3: Assembly Bill (AB) 254 (Thurmond)
Presenter: Assemblymember Tony Thurmond

The Commission will consider supporting AB 254 (Thurmond)-Local Educational Agency Pilot for Overall Needs.

- Public Comment
- Vote

10:10 AM **Action**
4: Assembly Bill (AB) 1315 (Mullin)
Presenter: Norma Pate, Deputy Director, will introduce the representative from Assemblymember Mullin's office

The Commission will consider supporting AB 1315 (Mullin)-.Early Psychosis Detection and Intervention Competitive Selection Process Act.

- Public Comment
- Vote

10:30 AM **Action**
5: Technical Assistance Contract
Presenters: Brian Sala, Ph.D., Deputy Director and Norma Pate, Deputy Director

The Commission will consider authorizing entering into a contract with Alexan RPM to fund additional technical assistance and project management support for business processes and information technology projects.

- Public Comment
- Vote

11:00 AM **Action**
6: MHSA Fiscal Reversion Report
Presenter: Brian Sala, Ph.D., Deputy Director

The Commission will consider adopting the Fiscal Reversion Report submitted by the Fiscal Reversion Project Subcommittee.

- Public Comment
- Vote

11:45 AM **Action**
7: Modoc County Innovation Plan
County Presenter: Karen Stockton, Ph.D., M.S.W., B.S.N, Health Services Director

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

- Public Comment
- Vote

12:15 AM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

12:30 AM **Lunch Break**

1:45 PM **Action**
8: Kern County Innovation Plan
County Presenter: William Walker, LMFT, Director of Kern Behavioral Health and Recovery Services

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

- Public Comment
- Vote

2:15 PM **Information**
9: 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.

Informational Documents Enclosed:
Enclosed are: the motions summary from the March 23, 2017 Commission meeting; Evaluation Dashboard; Calendar of Commission activities; and Innovation Review Outline.

2:30 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

2:45 PM **Adjourn**

AGENDA ITEM 1A

Action

April 27, 2017 Commission Meeting

Approve March 23, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the March 23, 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: March 23, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve March 23, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the March 23, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
March 23, 2017

San Diego City College
Corporate Education Center, Room MS140
1551 C Street
San Diego, CA 92101

866-817-6550; Code 3190377

Members Participating:

Tina Wooton, Chair
John Boyd, Psy.D., Vice Chair
Reneeta Anthony
Lynne Ayers Ashbeck
Khatera Aslami-Tamplen
Sheriff Bill Brown
John Buck
Itai Danovitch, M.D.
David Gordon
Kathleen Lynch
Gladys Mitchell
Richard Van Horn

Members Absent:

Senator Jim Beall
Larry Poaster, Ph.D.
Assembly Member Tony Thurmond

Staff Present:

Toby Ewing, Ph.D., Executive Director
Norma Pate, Deputy Director
Brian S. Sala, Ph.D., Deputy Director
Filomena Yeroshek, Chief Counsel
Urmi Patel, Psy.D., Consulting Psychologist
Tom Orrock, Health Program Manager

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:03 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Chair Wooton stated Commissioners went on site visits yesterday to the Community Transition Center and the Vista Balboa Crisis Residential Treatment Center and heard a presentation on the Psychiatric Emergency Response Teams (PERT).

ACTION

1: Approve February 23, 2017, MHSOAC Meeting Minutes

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

The Commission approves the February 23, 2017, Meeting Minutes.

Motion carried 7 yes, 0 no, and 5 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Anthony, Ashbeck, Brown, Danovitch, and Gordon.

INFORMATION

2: Criminal Justice and Mental Health Project

Project Chair: Commissioner and Sheriff Bill Brown

Commissioner Brown stated this project is making great progress toward providing counties with a menu of options to design better systems for individuals with mental illness who intersect with the criminal justice system.

Panel 1: Jail and Re-entry Services

- Alfred Joshua, M.D., Chief Medical Officer, San Diego County Sheriff's Department
- Patricia Ceballos, Re-entry Supervisor, San Diego County Sheriff's Department
- Mona Minton, Ph.D., General Manager, Neighborhood House Association
- Cassandra Arnold, Certified Substance Use Case Manager, Project In-Reach

Alfred Joshua, M.D.

Alfred Joshua, M.D., Chief Medical Officer, San Diego County Sheriff's Department, stated he oversees the medical, mental, and dental health of the inmates in the seven jails in San Diego County. He equated the highly-structured jail health care system to a vertically-integrated health plan similar to Kaiser-Permanente. He provided an overview of the behavioral health services delivery system delivered by the Medical Services Division of the Sheriff's Department. He summarized the Jail Mental Health Services Model. Information on how this Model is structured and what services are provided was

included in the meeting packet. He described the uniqueness of the San Diego jail mental health programs, such as the Inmate Safety Program that includes Structured Health Assessments in an integrated approach, the new Jail-Based Competency Program partnering with Liberty Healthcare's Restoration of Competency Program, and the future online Chronic Suicide Unit.

Commissioner Questions and Discussion

Commissioner Aslami-Tamplen asked about including peers on the multidisciplinary team. Dr. Joshua stated the county is currently working with community partners to include peers in discharge planning. He stated the challenge is that the individuals who may be the best workers to help inmates sometimes do not pass the background check to be allowed to work inside of facilities.

Vice Chair Boyd encouraged the county to use more person-first language, such as changing the term "mental health patients" to "individuals who have a mental illness" or "individuals who happen to have a mental health challenge" and also changing the name of the Chronic Suicide Unit. Dr. Joshua agreed and stated the name for the Chronic Suicide Unit was included in the handout for quick understanding but will be changed once it is operational.

Commissioner Van Horn agreed and encouraged members of the health and mental health communities to use a different term other than "the mentally ill."

<u>Patricia Ceballos</u>

Patricia Ceballos, Re-entry Supervisor, San Diego County Sheriff's Department, stated the re-entry component starts from the moment an individual is brought into custody. The Sheriff's Department Re-entry Services Division focuses on assessments to learn about each individual's risks and needs and how supportive services and evidence-based programming can be provided. Case managers follow individuals through their custody stay, build relationships, connect individuals to community partners, and work with the Probation Department to provide a multidisciplinary team approach to supervision upon release.

Ms. Ceballos stated the Sheriff's Department created a local workforce partnership and received a grant to put a job center in a jail. The job center provides vocational education training and long-term programs designed to build skills. In addition, the job center invites employers into facilities to interview individuals while they are still in custody.

Commissioner Questions and Discussion

Commissioner Anthony stated it is difficult for family members to locate information regarding their incarcerated loved ones. She asked what kind of documentation or information is provided on the Sheriff's Department website that explains the discharge process as well as the information that was presented today. Ms. Ceballos stated the website includes a breakdown of classes, programs, and other services that are available. She also stated correctional counseling staff are stationed at all facilities who can help answer family member questions.

Commissioner Anthony asked how language differences are addressed in the website information. Ms. Ceballos stated the website has been translated into several languages and interpreters are also available to help over the phone.

Commissioner Brown asked about outside employment partnerships and the types of jobs that are typically available. Ms. Ceballos stated the county is still learning. She gave examples of employers that attended the job fair to hire individuals from food service, hospitality, construction, and truck driving industries.

Mona Minton, Ph.D.

Mona Minton, Ph.D., General Manager, Neighborhood House Association (NHA), provided a brief summary of the background, goals, and challenges of the NHA Project In-Reach (PIR) program and explained how it helps individuals with behavioral health needs who are incarcerated re-enter the community. Dr. Minton's paper detailing the PIR program was included in the meeting packet.

Commissioner Questions and Discussion

Vice Chair Boyd asked how resiliency is maintained in the workforce and what kind of recruitment or shortage issues are faced. Dr. Joshua stated there is stigma associated with working in corrections and it is difficult to remove the perception that the jail is not a safe place to work. Recruitment is focused on educating individuals who have buy-in with this population to remove the misconceptions not only for the person being recruited but for their family members. Dr. Joshua also stated the need for creative interventions in tele-psychiatry and a more team-based approach to combat the shortage of psychiatrists.

Ms. Ceballos stated the majority of re-entry staff come from the nonprofit world and are now bringing that experience into a custodial setting. She encouraged including the support team members' attendance in client graduations from programs to carry on the support system from a custodial setting into a community setting.

Dr. Minton agreed that community collaboration is important. Housing is the greatest challenge in San Diego County to helping these individuals survive in the community.

Cassandra Arnold

Cassandra Arnold, Certified Substance Use Case Manager, PIR Program, shared her personal experience with the criminal justice and mental health systems and how she now works in the field to help peers overcome obstacles and to have hope that they can change their lives for the better. She stated she encourages peers to use their time while serving time in a positive manner to show future employers that they will make good employees.

Commissioner Questions and Discussion

Commissioner Mitchell stated, regarding maintaining resilience to find the right employees, some programs fail because of recruitment efforts. She encouraged looking for individuals in this field because it is not only a passion but a calling and a commitment. She stated Ms. Arnold is an example of the passion and grit it takes to be successful in this field.

Commissioner Van Horn stated the hope that Dr. Joshua could impact the regulatory environment so that individuals like Ms. Arnold do not have to wait years and beg for permission to give to the community.

Commissioner Brown thanked the panel for their presentations and for the work that they do in leveraging community resources by working in community-based partnerships and being examples for others to follow. He stated he agreed with Dr. Minton that housing is one of the largest problems throughout California. He stated that for individuals in custody, co-occurring substance abuse is interlinked with mental illness and both issues should be treated at the same time while they are in custody. He stated traditional barriers need to be broken down in the custody field, in the community at large, and in the mental health community.

Panel 2: County Approaches to Improving Outcomes

- Jay Orr, Riverside County Executive Officer
- Garry Herceg, Deputy County Executive, Santa Clara County

Jay Orr

Jay Orr, Riverside County Executive Officer, shared his background and the circumstances that led him to focus on working across local agencies to create system change, working on the cost drivers associated with reducing the incarceration of those with mental illness, and working on the investments in sustaining system change effort over time as set out in detail in his presentation notes, included in the meeting packet. He emphasized that the concern for mental illness needs to begin with the first contact with law enforcement, not when individuals get to an institution. Law enforcement personnel are inadequately trained to deal with mental illness in the field. Mr. Orr stated, in order to address mental illness, children's services need to be expanded across the behavioral health system.

Commissioner Questions and Discussion

Commissioner Van Horn agreed and stated the Commission is also doing work on mental health and education, specifically for first and second graders.

Commissioner Gordon stated the Commission is looking for counties that would be interested in a pilot county/school district relationship program attacking the problem of very young children who teachers know have needs and are unable to access care. He asked Mr. Orr if Riverside County would be interested in participating in the pilot project. Mr. Orr stated he would be interested and stated stakeholders have met to discuss how to work across siloes to develop a resiliency program in his county. Commissioner Gordon stated he will follow up with Mr. Orr offline.

Vice Chair Boyd stated he would like to see more county executives at Commission meetings.

Commissioner Aslami-Tamplen asked about the jail study including race/ethnicity of the population ending up in jail as compared to the communities. She asked if Riverside County worked with experts in the community to help reach out to specific populations to provide more upstream services. Mr. Orr stated the California Forward study looks at race and age. A particular group was not targeted to do intervention.

Garry Herceg

Garry Herceg, Deputy County Executive, Santa Clara County, gave a brief overview of the adopted recommendations from the Jail Division and Behavioral Health Subcommittee (JDBHS) and the Data Driven Justice Initiative. The overview included discussion on the cost drivers associated with the county system and investments in sustaining systems change efforts over time as set out in detail in his presentation notes, included in the meeting packet. He stated the county partnered with other departments to create a multidisciplinary supervision team that is expected to kick off on April 18, 2017. The county is also creating a restoration center with a sobering center in a one-stop-shop, including medical assessments.

Commissioner Questions and Discussion

Commissioner Brown asked about the difference between the fixed and marginal costs of an average jail bed day and the impact that minimal staffing has. Mr. Herceg stated if the number of individuals in jail is reduced, jail bed costs will go up. The costs of a jail change daily based on population.

Commissioner Brown asked about building a 40-bed mental health treatment facility and how Santa Clara County will get around the 16-bed reimbursement rule. Mr. Herceg stated 16 of the 40 beds will be crisis residential beds and the remainder will be substance treatment beds. He stated he was unable to answer questions about the financing of the facility.

Commissioner Brown asked if the same staff will be used throughout the facility. Mr. Herceg stated the county is contracting out to staff the facility. Commissioner Brown stated that is an innovative idea to possibly get around the reimbursement rule.

Commissioner Buck stated this issue is not uncommon, especially for smaller counties that have a larger existing facility. The way to get around the rule is to put a double door in the hallway to split off the 16 beds from the other beds. New construction is appealing but expensive.

Commissioner Aslami-Tamplen stated there are reasons behind the Institute for Mental Disease Regulations to keep from going back to warehousing individuals in facilities. Patients receive more individualized care when the number of beds is held at 16. She suggested the Peer Respite Model as an alternative in Santa Clara County.

Commissioner Ashbeck asked what the Commission can do to support boards of supervisors to engage more. Mr. Herceg asked for help spreading the word to put programs in place today that may reduce the jail population in the future, to do things that are proven to work, to reassess current practices to ensure they work in today's climate, and to look at data to inform decisions.

Mr. Orr stated the need to work collaboratively across silos in a multidisciplinary approach. It is difficult to change thinking from a categorical funding model to social problems.

Commissioner Ashbeck suggested spreading the word through ongoing training in behavioral health through the California State Association of Counties (CSAC)

academy. Mr. Herceg requested that the Commission take that idea also to the Judicial Council and the education of new judges.

Panel 3: Best Practices in the Community and in Custody

- Stephen Amos, Chief of Jails Administration, National Institute of Corrections (NIC)
- Jennie M. Simpson, Ph.D., Substance Abuse and Mental Health Services Administration (SAMHSA)

Stephen Amos

Stephen Amos, Chief of Jails Administration, NIC, stated the NIC is a clearinghouse for information and best practices and provides technical assistance and training. He provided a brief overview of the national outlook, where California stands in that mix, and the efforts that are currently being undertaken to address individuals with mental illness and substance abuse disorders as set out in detail in his presentation notes. His notes are included in the meeting packet. He highlighted promising behavioral health initiatives currently underway, such as the Stepping Up Initiative in which this Commission was a partner, the NIC Mental Health Jail Assessment findings, and expanded services to the field.

Commissioner Questions and Discussion

Vice Chair Boyd asked where the nation is on influencing and reducing stigma, dealing with social prejudice, and how to effectively move the conversations along throughout the country. Mr. Amos stated Assembly Bill (AB) 109 was a watershed event to recognize that not everyone can be sent to the California Department of Corrections and Rehabilitation (CDCR) as a solution, and yet the jail population continues to expand. California is on the cutting edge of figuring out how to deal with this realignment, and AB 109-impacted counties are at the tipping point and need additional services. He stated he sees a major shift in national policy and direction; there is less stigma associated with this than twenty years ago.

Chair Wooton encouraged continuing to include persons with lived experience in the Crisis Intervention Team (CIT) training programs.

Jennie M. Simpson, Ph.D.

Jennie M. Simpson, Ph.D., Office of Policy, Planning, and Innovation, SAMHSA, stated it is important to recognize that substance use disorders and mental illness are both brain disorders. She provided a brief summary of the background, goals, and challenges of SAMHSA and highlighted SAMHSA's behavioral health and criminal justice programs, best practices around diversion, and training and technical assistance support for counties as set out in detail in her presentation notes. Her notes are included in the meeting packet. She stated the Sequential Intercept Model is used by SAMHSA as a framework for criminal justice programs.

Commissioner Questions and Discussion

Commissioner Danovitch asked if the current administration has signaled the intent to change support for SAMHSA and its mission and how SAMHSA is managing any uncertainty around that. Dr. Simpson stated SAMHSA is heartened by the 21st Century Cures Act, which reauthorizes SAMHSA as an agency. She stated this shows that Congress has an investment in programs that address the critical intersection between behavioral health and criminal justice.

Commissioner Aslami-Tamplen emphasized the importance of peer specialists providing direct contact in mobile crisis teams. She stated individuals in the criminal justice system have a choice to be involved in court processes but those in the assisted outpatient treatment do not have that choice. There is a need to educate lawmakers. Dr. Simpson stated one is a civil process and the other is a criminal process and the choice for the criminal process may be incarceration or probation.

Commissioner Anthony thanked SAMHSA for many years of providing free access to very important information on its website.

Public Comment on All Panels

Jim Gilmer, President, Mental Health America of California (MHAC), member of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the Ventura County Multicultural Coalition, stated individuals of color are overrepresented in the criminal justice system. Race affects every discretionary point in the system; even attempted race-neutral policies and strategies can yield different treatment and outcomes, which are referred to as racial and ethnic disparities. Attempts to deliver mental health services, if not done culturally appropriately through racial/ethnic/LGBTQ/faith lenses, will be inefficient. He suggested hosting a convening involving stakeholders to discuss reducing racial/ethnic disparities in the system, particularly around mental health. Small successes can be the engine to a broader transformation of the criminal justice system. He stated he emailed informational materials to staff.

Stacie Hiramoto, Director, REMHDCO, agreed with Mr. Gilmer's comments. She cautioned the Commission against depending on evidence-based practices. Those practices have not always been tested in communities of color. Each community knows what practices work for them. She asked that Commission meetings include a panel of members of the community who have best practices to share. She suggested that the Commission connect its school and criminal justice projects to look at what is known as the "school-to-prison pipeline."

Hilary Carson, MHSA Innovations Program Administrator, Behavioral Health at Ventura County Health Care Agency, referred to Panel 3 and stated she was excited to hear the systems are speaking with each other. She stated another restriction in older jail facilities is that visitation rooms are not set up for contact visits. She asked the panel members to encourage facilities to think outside the box and find a way to facilitate visits where a parent and child can give each other a hug. Years without physical affection can impact mental health.

GENERAL PUBLIC COMMENT

Rebecca Paida, Senior Program Manager at Nile Sisters Development Initiative, stated she represents over 150,000 refugees in San Diego County. Consistently, San Diego County has been the chief refugee resettlement site in the state of California. She gave examples of refugees with mental and behavioral health issues who were killed by local law enforcement. She stated resources are lacking to provide help to the many refugees who are severely affected by mental and behavioral health issues. There is a lack of culturally and linguistically proficient providers, limited efforts to engage refugee youth in a meaningful way, and severe homelessness in the refugee community. The refugee community also has substance abuse and domestic violence. There are no efforts to prepare individuals with lived experience from these populations to become lay health care workers or medical practitioners who can directly address the needs of their community. There are no efforts on the county's part to engage ethnic community-based organizations, the gatekeepers who have direct access to these communities, to address mental and behavioral health concerns. There are also no efforts to compile evidence-based literature on refugees or conduct needs assessments. She emphasized the need to address these pressing issues.

ACTION

3: San Diego County Innovation Plans

County Presenters: Holly Salazar, MPH, Assistant Director, Departmental Operations for Behavioral Health Services; Piedad Garcia, Ed.D., LCSW, Deputy Director, Adult and Older Adult Behavioral Health Services; Laura Vleugels, M.D., Supervising Child and Adolescent Psychiatrist, Children, Youth and Families Behavioral Health Services; Jeffrey Rowe, M.D., Supervising Psychiatrist, Juvenile Forensics Division; Michael Miller, LMFT, Behavioral Health Program Coordinator; Adrienne Collins Yancey, MPH, MHSA Coordinator

Vice Chair Boyd stated the importance of describing what is innovative or different about the proposed innovation plans and being specific about why the county is requesting a renewal for what appear to be well-established programs.

Holly Salazar, MPH, Assistant Director, Departmental Operations for Behavioral Health Services, stated the proposed projects align with the board of supervisors adopted Live Well San Diego vision. She provided a brief overview, accompanied by a slide presentation, of the demographics and community planning process in San Diego County and the Cycle 3 Change Requests.

Innovation 11, Caregiver Connection

Jeffrey Rowe, M.D., Supervising Psychiatrist, Juvenile Forensics Division, continued the slide presentation and discussed the purpose and proposed change of the first of five proposed projects, Innovation 11, Caregiver Connection.

Commissioner Questions and Discussion

Commissioner Danovitch asked what was learned from part one of the Caregiver Connection project. Dr. Rowe referred to the eight-page report. Dave Summerfeld, UCSD, Evaluator for the innovation projects, detailed the small sample size, outcomes, and learnings that took place during the first year.

Commissioner Danovitch asked, since the county has yet to demonstrate outcomes as anticipated during the first phase of the Caregiver Connection, why is the county not seeking to extend using the lessons learned versus beginning to scale up to include other populations or other areas. Dr. Rowe stated the county hopes to figure out how to fund these programs in other ways, so it is not just about expansion of numbers but is about learning about younger children and the support of their caregivers.

Commissioner Van Horn asked how many children and families are in the Caregiver Connection program now. Ginger Bial, Program Manager, KidSTART Clinic, stated there is an average of 150 to 170 children and 80 caregivers.

Commissioner Van Horn stated the proposed Caregiver Connection is innovative, but it is important to know that the anticipated 300 children will be in the program, how soon that number can be reached, and if there will be matched caregivers for each child in order to make the program statistically and anecdotally important.

Vice Chair Boyd asked for greater detail on the budget for the Caregiver Connection program. Michael Miller, LMFT, Behavioral Health Program Coordinator, stated the proposed budget is almost the same as the original budget.

Vice Chair Boyd asked if the county pulled from research or models as a foundation for the proposed Caregiver Connection project. Dr. Rowe stated county clinicians wanted to find a way to engage parents and caregivers. The fear was that that there would be overwhelming numbers and nothing clinicians could do for them. Another component of the learning is how to find the parents and caregivers who need help, and then how to link them to existing services.

Vice Chair Boyd asked about clear data outcomes from the work to date. It is difficult to understand the measures used to manage the work, populations, and volume. Dr. Rowe stated the program tracks the number of caregivers that present to care and how many collateral events happen. This project measures, if the caregivers intervene, how that will alter the basic outcome predictors. Expanding the program to ages 6 to 18, the county can compare across the usual system of care assessment done annually.

Commissioner Anthony asked about the difficulty in engaging families from different backgrounds and races and the kind of changes the county plans to make for the future. Dr. Rowe stated it will not be simple because they will be operated by outside contractors who will be required to submit how they plan to engage and meet needs with the diverse population.

Commissioner Ashbeck asked about the difference between clients served and screened and why the county is asking for an extension when the Caregiver Connection project still has 18 months to go. Dr. Rowe stated Phase 1 described what it takes to engage and support parents and caregivers of young children. The proposal is to

expand the project to include older children to apply what is learned to a continuation of service in the whole system.

Commissioner Danovitch stated this is an important issue for which innovations are needed, but it would be easier to think of the county's proposal as a new project rather than an extension of the Caregiver Connection project because the current project is still in development and it is unknown whether Phase 1 will be successful and scalable.

Commissioner Buck asked what percentage of the $2.17 will be indirect administrative costs and if this includes the evaluation component. Mr. Miller stated the evaluation component is built in as 5 percent of the overall allocation. The salary and benefits portion is $186,000, the operating cost is $5,000, and the indirect cost is $28,493.

Innovation 12, Family Therapy Participation

Dr. Rowe continued the slide presentation and discussed the purpose and proposed change of the second proposed project, Innovation 12, Family Therapy Participation.

Commissioner Questions and Discussion

Commissioner Van Horn stated the Family Therapy Participation project relates closely to the Caregiver Connection project. Dr. Rowe stated the Caregiver Connection is to identify which caregivers need their own care and the Family Therapy Participation is to involve families in therapy with their children.

Commissioner Mitchell asked for greater detail on the role of the parent partner. Dr. Rowe stated the parent partner is an individual with lived experience who has been trained in interpersonal interactions, dealing with individuals who are having trouble, and motivational interviewing to encourage individuals to participate in the project with a therapist.

Commissioner Danovitch asked what this project will allow the county to learn that cannot be learned by literature review, models of care, and best practices. Dr. Rowe stated there is no literature on the engagement of parents by parent peers to overcome barriers to family therapy using motivational interviewing in a community mental health clinic setting with children and families.

Commissioner Aslami-Tamplen added that another innovative piece is focusing on underserved communities, particularly African American and Latino populations.

Commissioner Mitchell stated trust is built by hiring employees that look like the community. Dr. Rowe stated there are over 100 different communities in San Diego County. One of the reasons the county is asking for an extension is to have better representation and greater focused interaction with families. Six clinics is not enough.

Commissioner Ashbeck asked if the primary metric of this project is the number of families engaging in family therapy or the impact of families engaged in family therapy on the children's outcomes. Dr. Rowe stated it is both.

Commissioner Anthony asked how the scope of work in the Request for Proposal (RFP) will address the engagement process to be more effective in the Family Therapy Participation project. Dr. Rowe stated respondents will be required to explain who they serve, the cultural and linguistic background of their staff, how they will be trained in

motivational interviewing, and how they plan to make the engagement process more effective. The RFP will include the requirement to hire peer providers with language skills and cultural experiences that would match the respondent's population.

Commissioner Anthony asked about the total number served through the Family Therapy Participation project. Dr. Rowe stated the target population was 480 families but to date the project has served 530 families. The proposed expansion will increase the target to include another 480 families.

Innovation 15, Peer Assisted Transitions

Piedad Garcia, Ed.D., LCSW, Deputy Director, Adult and Older Adult Behavioral Health Services, continued the slide presentation and discussed the purpose and proposed change of the third proposed project, Innovation 15, Peer Assisted Transitions.

Commissioner Questions and Discussion

Commissioner Ashbeck asked about the amount of funds requested. Charity White Voth, Program Coordinator and Monitor of the Peer Assisted Transitions project, explained the reason for the proposed $3 million is to serve 60 extra participants.

Commissioner Mitchell stated the presentation did not help Commissioners understand the Peer Assisted Transitions project, why it needs to be expanded, and why it requires an extra $3 million for only 60 additional participants.

Luce Pinto, Director, Peer Assisted Transitions project, asked to speak with Ms. White Voth offline to clarify the budget because it was different than represented to her.

Commissioner Brown stated the budget is for $683,000 for three one-year cycles, which comes to just over $2 million, but the request is for $3.2 million. He asked what the additional $1.2 million is for. Ms. Pinto stated the extra amount is because the program is being extended by a year and a half. The math is harder to understand because the $3 million does not only cover the 60 extra participants and team but will also include the 200 annual unduplicated clients from Phase 1.

Dr. Garcia directed Commissioners to the full report, which describes the project in greater detail, that was sent to the Commission.

Innovation 16, Urban Beats

Dr. Garcia continued the slide presentation and discussed the purpose and proposed change of the fourth proposed project, Innovation 16, Urban Beats.

Commissioner Questions and Discussion

Commissioner Van Horn asked why the county is asking to extend this project for one year when it asked to extend the Peer Assisted Transitions project for two years. Cecily Thornton-Sterns, Behavioral Health Program Coordinator, County of San Diego, stated the county felt it could obtain the learnings sought in one year.

Commissioner Ashbeck asked what makes the county think they can reach the target of 800 within the one extended year when it has served only 94 clients out of the 600 targeted in Phase 1. Dr. Garcia stated the 94 TAY clients have taken a survey with information required by the MHSA and have been trained over a five-month period on

what mental health is, what it means to seek services, and how to impart age-appropriate messaging to other TAY to bring that message through artistic expression. The 94 TAY have presented 15 performances and reached 1,000 TAY during the last two years who have not completed the two-page survey because of the demographics and questions asked. A new way must be found to get their input. This program has a social media campaign to engage TAY with over 21,000 users. The 94 TAY listed in the slide is a core number that, over a period of time, gets involved, trained, and educated, manages their own wellbeing, and passes on a message through social media and various artistic expressions.

Commissioner Ashbeck asked if the goal is for 600 TAY to complete the survey. Ms. Garcia stated TAY are not completing the survey so the county plans to modify that area in Phase 2.

Commissioner Van Horn suggested that the county ask for two additional years if they plan to change the survey to get an improved level of participation. He asked that the county rework the numbers, fix the issues Commissioners mentioned, and represent the innovation projects at the next Commission meeting.

Innovation 17, CREST Mobile Hoarding Units

Dr. Garcia continued the slide presentation and discussed the purpose and proposed change of the fifth proposed project, Innovation 17, CREST Mobile Hoarding Units. She stated this project will include a focus on the Latino community.

Commissioner Questions and Discussion

Commissioner Van Horn stated the funding requested seems large for only serving 50 individuals over five years. He asked if this project is as intensive as the Full Service Partnership (FSP) program because the cost per person is approximately the same. Dr. Garcia summarized what the project would include and stated the salaries alone would be $178,000.

Commissioner Danovitch stated the research questions in the slide presentation sound like research questions as opposed to quality improvement questions. Although they are important questions, in order to answer them, the model or intervention must be compared to something else and there must be a design to ensure that comparison is significant. If it is a quality improvement approach, the question becomes how to implement and establish best practice of evidence-based intervention. He suggested revising that language if the county takes Commissioner Van Horn's suggestion to rework the proposals. Connie German-Marquez, Program Coordinator, clarified that the project will serve 50 clients per year. Dr. Catherine Ayers stated there are outcomes in the community that can be used as comparison, such as Adult Protective Service (APS) records.

Vice Chair Boyd agreed with Commissioner Mitchell's earlier concerns. He asked the presenters if they would be willing to rework their proposals and represent the innovation plans at the next Commission meeting. Ms. Salazar stated the presenters would like to regroup and bring their proposals back to the Commission at a future date.

Commissioner Brown suggested San Diego County present their updated proposals in six months to a year and take the opportunity to gather stronger data as the current

projects progress. He requested that, when the county presents their innovative plans to the Commission in the future, the presenters stress what is innovative about these projects.

Commissioner Aslami-Tamplen suggested that the county highlight the projects' focus on underserved communities during their presentation as is detailed in the report included in the meeting packet.

Commissioner Mitchell asked for greater clarity on the budget presentation.

Commissioner Ashbeck stated it was hard to understand the county's asking to extend programs that have not yet been proven. She suggested adding a section detailing what is innovative in the staff reports on the innovative projects.

Commissioner Anthony stated it would be helpful if there were clear understanding between all the presenters about the program, budget, and numbers served, incorporating some philosophy about what will be looked for in the bids.

Vice Chair Boyd stated that Commission staff is available to provide technical assistance.

Public Comment

Jama Mohamed, Nonprofit United Young Men of East Africa, stated he is working on a mental health initiative with the Prevention Institute and the Movember Foundation. San Diego County ranks second in the nation for African refugees. He stated the East African community is not comfortable speaking of mental health, is struggling, and is in need of mental health services.

Dawniell Zavala, Mental Health America of Northern California (NorCal MHA), stated she takes issue with the county's definition of peer specialist coaches in the Peer Assisted Transitions project because it is specified in the plan that they are not required to have lived experience. She asked why the county would call them a peer if they do not have lived experience. She suggested that the county make changes to the operations to bring greater success to their peers. She questioned why the county is seeking 95 percent of the current budget to serve a quarter of the clients and how the project is innovative.

ACTION

4: <u>Orange County Innovation Plan</u>

County Presenters: Flor Yousefian Tehrani, Psy.D., LMFT, Innovation Projects Interim Program Manager; Terri Styner, MSW, Innovation Projects Service Chief; Sharon Ishikawa, Ph.D., MHSA Coordinator

Flor Yousefian Tehrani, Psy.D., LMFT, Innovation Projects Interim Program Manager, provided an overview, accompanied by a slide presentation, of the challenges and barriers of military-connected families in Orange County. She proposed a new Innovation project, the Continuum of Care for Veterans and Military Families, that is designed to integrate veteran-specific training and services in the Orange County Family Resource Centers (FRCs), which are traditionally not focused on serving military families.

Commissioner Questions and Discussion

Commissioner Van Horn asked, of the 15 FRCs in the county, how many of them are school-based. Dr. Tehrani stated they are in a variety of settings - some FRCs are embedded in schools, while others are in neighborhood locations.

Commissioner Boyd asked how many veterans currently seek care in the FRCs. Dr. Tehrani stated there are approximately 12 families per FRC.

Commissioner Boyd asked why the county is proposing use of Innovation funds rather than Prevention and Early Intervention (PEI) funds. Dr. Tehrani stated the county wanted to test the effectiveness of something new comparing trained FRC staff to the best practice of veteran peer navigators. They could not use PEI funds because this has not yet been proven an effective method which is required by the PEI regulations.

Commissioner Boyd asked why veterans are accessing the FRCs. Dr. Tehrani stated that is part of the concern. Currently, there is no data to track that. This project focuses on the needs of that target population and how services can be improved.

Commissioner Boyd stated, outside the physical place where services will be delivered, he did not see innovation in this project. Sharon Ishikawa, Ph.D., MHSA Coordinator, stated peer navigators who are embedded in the FRC facilities are considered the control group; they are the best-practice standard. The county wanted to see how the success rates of non-peer FRC staff who are provided military culture training compare to the success rates of peers.

Commissioner Boyd asked, since peer navigators are a proven best practice, why the county is not expanding that rather than training non-peers to attempt to do what only peers can do. Peers can educate the rest of the workforce on military culture. Terri Styner, MSW, Innovation Projects Service Chief, stated the county outreach and engagement teams do outreach primarily to the homeless or individuals at risk of being homeless. They go out with the VSO to reach veterans and ask if they know other veterans, but they do not reach families who are not homeless. Also, current contracted programs focus on education and support groups and do not offer direct services to families.

Commissioner Danovitch stated the proposal was well written and presented. He asked about the learning goal measurement. Dr. Ishikawa stated the project will compare the success rates of non-peer FRC staff who are provided military culture training to the success rates of peer navigators and will compare potential improvements in global health or symptom reduction using both statistical differences in the scores between the two groups and clinical improvement.

Commissioner Lynch asked about the role of the project manager. Dr. Tehrani stated the project manager will handle the intake and administrative paperwork and staff recruitment, and will provide support, supervision, and coordination between the 15 RFCs.

Commissioner Brown asked how a veteran or military-connected family is defined in this project. Dr. Tehrani stated the target population is anyone who is in active duty, a reservist, or a spouse, family member, loved one, or child who is connected to the military.

Commissioner Brown asked how duplication of services is addressed and if there will be collaboration with the VA for individuals seen there in the past or who may be better served by the VA. Dr. Tehrani stated the goal of the project is to get help to military families by assessing the services they are looking for, if they have been connected to other services, and if the VA may provide more appropriate services.

Public Comment

Poshi Walker, NorCal MHA, stated veterans deserve everything civilians are qualified for plus VA care if they are eligible. Being a veteran should never preclude someone from getting mental health care from the public mental health system. She stated the military culture is unique - different from any other culture she has seen. She agreed that staff needs cultural competence training, but also agreed with Vice Chair Boyd's concern about the use of non-peers in place of a military peer navigator. If there are situations where a military peer navigator is not available, that is the need that should be addressed, not trying to make another person perform that role.

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

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

Name: Continuum of Care for Veterans and Military Families

Amount: $3,083,777

Program Length: Five (5) Years

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

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

The following Commissioners voted "No": Vice Chair Boyd and Commissioner Mitchell.

ACTION

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

County Presenters: Kiran Sahota, MA, MHSA Manager; Hilary Carson, MSW, MHSA Administrator, Innovations; Genevieve Flores-Haro, MPA, Associate Director, Mixteco/Indigena Community Organizing Project; Henry E. Villanueva, Ed.D., Behavioral Health Manager, Quality Assurance; Patricia Gonzales, Ph.D., Research Psychologist, Quality Improvement Department

Kiran Sahota, MA, MHSA Manager, provided an overview, accompanied by a slide presentation, of the history of the Mixteco population in Ventura County.

Arcenio Lopez, Executive Director, Mixteco/Indigena Community Organizing Project, continued the slide presentation and discussed the needs of the Mixteco population in Ventura County.

Henry Villanueva, Ed.D., Behavioral Health Manager, Quality Assurance, continued the slide presentation and discussed the proposed program and challenges. He stated this Innovative project is applicable to a wide range of situations and populations.

Hilary Carson, MSW, MHSA Administrator, Innovations, continued the slide presentation and discussed the program description, learning goals, outcomes, and budget. She stated the proposed budget is for four years, although the project is anticipated to run for three years.

Commissioner Questions and Discussion

Commissioner Brown stated he wanted to clarify publicly that this project is not limited to the Mixteco population exclusively.

Commissioner Aslami-Tamplen stated this project will be helpful for communities and is especially important now.

Commissioner Ashbeck stated this project could be replicated in Fresno County.

Commissioner Danovitch stated it is important to systematically record the barriers encountered during this project. He asked the county to think about how to disseminate the information on this project once it is over.

Commissioner Brown stated the hope that Santa Barbara County could call upon Ventura County as a regional approach. Ms. Sahota stated she welcomed that idea and suggested including law enforcement involvement, as well.

Vice Chair Boyd stated PEI he loved this project but needs to ask these questions for consistency because he asked them to the other counties. He stated that PEI funds has been used for this population before by the county and asked how a different type of learning will be produced with this project. He also asked how this project is different from other research including Ventura County's past work. Ms. Carson stated it is different because the information gained will be used for clinical treatment and services.

Vice Chair Boyd asked how that will be different from, for example, the UC Davis Disparities Report. Dr. Villanueva stated MICOP has been an exceptional partner in helping to somewhat build a bridge to the community, but does not provide clinical work. This project has the potential to become an evidence-based practice if pursued correctly and if the county uses all the tools and measurements available.

Public Comment

Victoria Gomez spoke through an interpreter in support of the proposed innovative project.

Louisa Leon spoke in support of the proposed innovative project.

Raymond Diaz, California Pan Ethnic Health Network (CPEHN), urged the Commission to approve this project.

Action: Commissioner Aslami-Tamplen made a motion, seconded by Chair Wooton, that:

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

> *Name: The Mixteco Project: Healing the Soul*
>
> *Amount: $838,985*
>
> *Program Length: Four (4) Years*

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

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

ACTION

6: Award of Stakeholder Contracts

Presenters: Tom Orrock, Health Program Manager and Angela Brand, MHSOAC Staff

Tom Orrock, Health Program Manager, thanked staff for all their hard work on this project.

Angela Brand, MHSOAC Staff, provided an overview, accompanied by a slide presentation, of the Requests for Proposals (RFP) for the six Stakeholder contracts. She briefly explained the background, timeline, scoring process, and results of the RFP process. She announced the names of the organizations that scored the highest number of points for each stakeholder group category. The organizations with the highest points were:

- Clients/Consumers: Mental Health America (MHA) of Northern California
- Diverse Racial/Ethnic Communities: National Alliance on Mental Illness California (NAMI California)
- Families of Clients/Consumers: NAMI California
- LGBTQ: Health Association Foundation
- Parents/Caregivers of Children and Youth: United Parents
- Veterans: California Association of Veteran Service Agencies (CAVSA)

Executive Director Ewing stated all materials from the RFP process will be made public. He stated Commissioners had stated the need to increase competition after the first round. Although applications were received from organizations that were new to the Commission and to the MHSA, more work needs to be done to increase competition. The quality of the proposals was good; progress was made to improve the Commission’s ability to use these funds to empower organizations to do the kinds of outreach and advocacy that is necessary for the goals of the MHSA to take effect.

Commissioner Questions and Discussion

Commissioner Danovitch expressed appreciation for all the work that staff put into this process.

Commissioner Mitchell asked if there were any wide discrepancies in the scoring from individuals. Ms. Brand stated the scoring was done through a consensus process and individual preliminary scores were fairly consistent.

Commissioner Mitchell asked how many participants attended the bidders’ conference. Ms. Brand stated there were 30 in-person attendees and several individuals on the telephone.

Commissioner Gordon asked if any of the contractors proposed subcontractors. Ms. Brand stated several proposals had subcontractors.

Public Comment

Sally Zinman, CAMHPRO, stated CAMHPRO applied for the Clients/Consumers Stakeholder Advocacy RFP and is disappointed. She asked about the appeal process and if the Commission will send copies of their application and others in their category.

Ms. Yeroshek asked Ms. Zinman to send an email request to staff today; the copies will be made available tomorrow. The Commission must receive an Intent to Protest by March 30th at 5pm. There is an additional five working days to provide a detailed written explanation of the reason for protest.

Karin Lottau, CAMHPRO, stated, even if CAMHPRO does not win the appeal, they will continue the work.

Raymond Diaz, California Pan-Ethnic Health Network thanked the Commission for the process and stated he looked forward to continued work with the Commission in the future.

Melen Vue, NAMI California, thanked the Commission for the process and stated she looks forward to working with staff on the diverse communities' contract.

Beth Wolf, NAMI California, echoed Ms. Vue's comments and was honored to be awarded the Families contract.

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

For each of the 6 RFPs, the Commission:

- *Authorizes the Executive Director to issue a "Notice of Intent to Award Contract" to the proposer receiving the highest overall score as follows.*
  - *16MHSOAC029 for Clients/Consumers: Mental Health America (MHA) of Northern California*
  - *16MHSOAC030 for Diverse Racial/Ethnic Communities: National Alliance on Mental Illness California (NAMI California)*
  - *16MHSOAC031 for Families of Clients/Consumers: NAMI California*
  - *16MHSOAC032 for LGBTQ: Health Association Foundation*
  - *16MHSOAC033 for Parents/Caregivers of Children and Youth: United Parents*
  - *16MHSOAC034 for Veterans: California Association of Veteran Service Agencies (CAVSA)*
- *Establishs March 30, 2017, as the deadline for unsuccessful bidders to file an "Intent to Protest" consistent with the five-working-day standard set forth in the Request for Proposals.*

- *Directs the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.*
- *Authorizes the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.*

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

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

INFORMATION

16: Executive Director Report Out

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

Executive Director Ewing presented his report:

Staff Changes/Vacancies

There are three staff vacancies left - one in the Evaluation Unit and two in the Innovation Unit.

Budget

The Budget Subcommittee hearing in the Senate is on March 30th and in the Assembly on April 3rd.

Executive Director Ewing stated the concern that, under the Rules of Procedure, he is authorized to spend up to $100,000 without asking for permission from Commissioners. He entered into two contracts at $90,000 each for a contractor but did not want to appear that he executed contracts just under the $100,000 to keep from asking the Commission for their permission. Prior to signing the contracts he discussed the two contract with the Chair. This issue revealed that the procedure needs review. The Commission contracts out its budget and accounting to the Department of General Services. He stated he has requested documentation of the records so staff can better monitor the budget and track the cash flow and checks that have been cashed, but those forms are so many months in arrears that staff does not know those figures. He stated he would like to present a budget to the Commission at the beginning of the year that projects upcoming operational expenses. He stated the budget process is not transparent to him and therefore is not transparent to Commissioners. The biggest problem is tracking the day-to-day expenditures. He stated the hope to present a monthly budget statement.

Legislation

The Commission is sponsoring three bills: Assembly Bill (AB) 462 by Assemblymember Thurmond, AB 862 by Assemblymember Ken Cooley, and AB 1134 by Assemblymember Gloria. They are set to be heard on March 28th or April 4th. Staff is working to move these bills to a single policy committee on April 4th.

Projects

Criminal Justice and Mental Health

Summaries of yesterday's fact-finding tour will be posted online. The next step will be to outline a set of findings and recommendations based on the work done to help identify areas that need further work.

Issue Resolution

A Draft Issue Resolution Report from the subcommittee will be completed in the next few months.

Regulation Implementation

There is a subcommittee meeting scheduled for April 12th to discuss the issue of how to deal with small counties. Potential amendments to the regulations will be presented at the May Commission meeting.

Reversion

The subcommittee met on Monday and approved a draft subcommittee report that will be presented at the April Commission meeting.

Schools and Mental Health

A site visit is scheduled for April 26th. Commissioners can email staff if they wish to attend.

Speaking Engagements

Chair Wooton has been asked to speak at the upcoming California Mental Health Advocates for Children and Youth Conference in May.

Commissioner Aslami-Tamplen has been asked to speak at the UCLA Behavioral Center of Excellence Conference focusing on disparities.

Triage

A Request for Application (RFA) for the second round of Senate Bill (SB) 82 triage grants will be presented at the May Commission meeting.

Staff is working with Office of Statewide Health Planning and Development (OSHPD) on their Workforce Education and Training (WET) program and the California Health Facilities Financing Authority on their piece of SB 82.

Commission Meeting Calendar

The April meeting will be at the Sacramento County Office of Education.

Commissioner Questions and Discussion

Chair Wooton asked staff to mention the requirement for peer employees for the SB 82 grants at meetings with OSHPD for the WET program.

GENERAL PUBLIC COMMENT

Amanda Walner, Health Access Foundation and the California LGBT Health and Human Services Network, stated she looked forward to working with the Commission

and other collaborative partners on the LGBTQ contract. She encouraged Commissioners to be involved in the federal health care discussion.

Ms. Walker stated NorCal MHA partners with Health Access Foundation and will co-direct the LGBTQ stakeholder contract. She thanked Vice Chair Boyd for making the motion that made the LGBTQ stakeholder contract possible.

Michael Hvesca, United Advocacy for Children and Families (UACF), thanked the Commission for the consideration for the Families contract. UACF has been advocating for children and families for over two decades and will continue the work.

Ms. Zinman stated CAMHPRO was in San Diego a month ago to do an Empowerment Networking Forum and Urban Beats youth put on a cross-generational program. She stated it was incredible.

ADJOURN

There being no further business, the meeting was adjourned at 5:21 p.m.

AGENDA ITEM 2

Action

April 27, 2017 Commission Meeting

Senate Bill 191: Pupil Health: Mental Health and Substance Use Disorder Services

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Summary: Carla Suporta, Legislative Consultant, from Senator Beall's Office will provide background and overview on Senate Bill 191 (Beall). This bill, as currently drafted, allows a county or a qualified provider, and a local educational agency to enter into a partnership to create a program that targets pupils with mental health and substance use disorders. The bill would also create the County and Local Educational Agency Partnership Fund from which moneys will be made available, to fund the partnerships. The bill requires the Commission in consultation with California Department of Education, Department of Health Care Services to develop guidelines on the county use of Mental Health Services Act funds for Innovative projects and Prevention and Early Intervention programs to support the partnerships.

Presenter: Carla Saporta, Legislative Consultant, Senator Beall's Office

Enclosures: Senate Bill 191; SB 191 Fact Sheet; Senate Committee on Education Analysis; Senate Committee on Health Analysis.

Handout: None

Recommended Action: Staff requests direction from the Commission regarding Senate Bill 191.

AMENDED IN SENATE MARCH 28, 2017

SENATE BILL No. 191

Introduced by Senator Beall
(Principal coauthor: Assembly Member Bonta)
(Coauthor: Assembly Member Maienschein)

January 30, 2017

An act to add Part 5.5 (commencing with Section 5920) to Division 5 of the Welfare and Institutions Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

SB 191, as amended, Beall. Pupil health: mental health and substance use disorder services.

Existing law requires school districts, county offices of education, and special education local plan areas (SELPAs) to comply with state laws that implement the federal Individuals with Disabilities Education Act, in order that the state may qualify for federal funds available for the education of individuals with exceptional needs. Existing law requires school districts, county offices of education, and SELPAs to identify, locate, and assess individuals with exceptional needs and to provide those pupils with a free appropriate public education in the least restrictive environment, and with special education and related services, including mental health services, as reflected in an individualized education program.

This bill would authorize a county, or a qualified provider operating as part of the county mental health plan network, and a local educational agency to enter into a partnership to create a program that includes, among other things, targeted interventions for pupils with identified social-emotional, behavioral, and academic needs and an agreement ~~to establish~~ *that establishes* a Medi-Cal mental health ~~and substance use~~

~~disorder~~ provider that is county operated or county contracted for the provision of mental health and substance use disorder services to pupils of the local educational agency and in which there are provisions for the delivery of campus-based mental health and substance use disorder services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an individualized education program (IEP), and pupils who do not have an IEP, but who a teacher believes may require mental health or substance use disorder services and, with parental consent, to provide those services to those pupils.

The bill would require the Mental Health Services Oversight and Accountability Commission, in consultation with the State Department of Education and the State Department of Health Care Services, to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the above-mentioned partnerships. The bill would create the County and Local Educational Agency Partnership Fund in the State Treasury, which would be available, upon appropriation by the Legislature, to the State Department of Education for the purpose of funding these partnerships, as specified, and would require the State Department of Education to fund these partnerships through a competitive grant program. The bill would also make related findings and declarations.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Student mental health and substance use problems are often
4 manifestations of childhood trauma, such as exposure to family
5 and community violence.
6 (b) Included among the numerous long-term negative health,
7 social, and educational outcomes associated with childhood trauma
8 are special health care needs, suicide attempts and depression,
9 alcoholism and injection drug use, learning difficulties and delays
10 on cognitive and social-emotional indicators, low school
11 engagement and attendance problems, repeating a grade and
12 academic failure, bullying, dating violence, delinquent behavior,
13 physical fighting, and weapon carrying.

(c) Investing in helping students effectively cope with and overcome trauma is particularly important for addressing substance use problems given the strong link between early adversity and substance use. For example, compared to individuals with zero Adverse Childhood Experiences (ACEs), individuals with four or more ACEs are 10.3 times as likely to have ever injected drugs, 7.4 times as likely to consider oneself an alcoholic, and 4.7 times as likely to have ever used illicit drugs.

(d) Mental illness and substance use disorders are so often cooccurring that a joint statement by the American Psychiatric Association and the American Society for Addiction Medicine concluded that it should be the expectation and not the exception. According to the Surgeon General, nearly 50 percent of people with substance use disorders have a cooccurring mental illness. The joint statement also concluded that when there is a cooccurring condition, it should be treated in an integrated program that simultaneously addresses both conditions.

(e) Schools are the best place for early identification and alleviation of behavioral health challenges that are likely to lead to serious mental illness or substance use disorders if not addressed early in their onset.

(f) Multitiered models to improve school climate and culture and to assure prompt referral for support for students showing any level of challenge and comprehensive integrated services for those with serious emotional disturbances or substance use disorders have been demonstrated to have the best outcomes in improving student health and academic performance.

(g) These integrated models, when able to leverage public or private health insurance funds, demonstrate that early investments pay for themselves in reduced special education costs and improved academic success with reducing school dropout rates and related problems.

SEC. 2. Part 5.5 (commencing with Section 5920) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 5.5. COUNTY AND LOCAL EDUCATIONAL AGENCY PARTNERSHIPS

5920. (a) Notwithstanding any other law, a county, or a qualified provider operating as part of the county mental health

1 plan network that provides substance use disorder services, and a
2 local educational agency may enter into a partnership to create a
3 program that, in addition to reflecting each school's specified
4 culture and needs, includes all of the following:
5 (1) Leveraging of school and community resources to offer
6 comprehensive multitiered interventions on a sustainable basis.
7 (2) An initial school climate assessment that includes
8 information from multiple stakeholders, including school staff,
9 pupils, and families, that is used to inform the selection of strategies
10 and interventions that reflect the culture and goals of the school.
11 (3) A coordination of services team that considers referrals for
12 services, oversees schoolwide efforts, and uses data-informed
13 processes to identify struggling pupils who require early
14 interventions.
15 (4) Whole school strategies that address school climate and
16 universal pupil well-being, such as positive behavioral interventions
17 and ~~supports or the Olweus Bullying Prevention Program,~~ *supports,*
18 as well as comprehensive professional development opportunities,
19 that build the capacity of the entire school community to recognize
20 and respond to the unique social-emotional, behavioral, and
21 academic needs of pupils.
22 (5) Targeted interventions for pupils with identified
23 social-emotional, behavioral, and academic needs, such as
24 therapeutic group interventions, functional behavioral analysis and
25 plan development, targeted skill groups, and eligible services
26 specified by the School-Based Early Mental Health Intervention
27 and Prevention Services Matching Grant Program pursuant to
28 subdivision (h) of Section 4380.
29 (6) Intensive services, such as wraparound, behavioral
30 intervention, or one-on-one support, that can reduce the need for
31 a pupil's referral to special education or placement in more
32 restrictive, isolated settings.
33 (7) Specific strategies and practices that ensure parent
34 engagement with the school and provide parents with access to
35 resources that support their children's educational success.
36 (8) Utilization of designated governmental funds for eligible
37 Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment
38 (EPSDT) services provided to pupils enrolled in Medi-Cal for
39 mental health and substance use disorder service costs, for
40 non-Medi-Cal enrolled pupils with an individualized education

program (IEP) pursuant to the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), and for pupils who do not have an IEP if the services are provided by a provider specified in paragraph (9).

(9) (A) An agreement ~~to establish~~ *between the county mental health plan, or the qualified provider, and the local educational agency that establishes* a Medi-Cal mental health ~~and substance use disorder~~ provider that is county operated or county contracted for the provision of mental health and substance use disorder services to pupils of the local educational agency. The agreement may include provisions for the delivery of campus-based mental health and substance use disorder services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an IEP adopted pursuant to Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794(a)) and pupils who do not have an IEP, but who a teacher believes may require those services and, with parental consent, to provide mental health or substance use disorder services to those pupils.

(B) The local educational agency, with permission of the pupil's parent, shall provide the county mental health plan provider with the information of the health insurance carrier for each pupil.

(C) The agreement shall address how to cover the costs of mental health and substance use disorder provider services not covered by funds pursuant to paragraph (8) in the event that mental health and substance use disorder service costs exceed the agreed-upon funding outlined in the partnership agreement between the county mental health plan, or the qualified provider, and the local educational agency following a yearend cost reconciliation process, and in the event that the local educational agency does not elect to provide the services through other means. *Nothing in this subparagraph shall hold the local educational agency liable for any costs that exceed the agreed-upon funding outlined in the partnership agreement.*

(D) The agreement shall fulfill reporting and all other requirements under state and federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and Medi-Cal EPSDT provisions, and measure the effect of the mental health and substance use disorder intervention and how that intervention meets the goals in a pupil's IEP or relevant plan for non-IEP pupils.

~~(E) The agreement shall provide for on-campus services by clinicians who are part of commercial insurance health plan behavioral health networks at schools where a significant percentage of students are not enrolled in Medi-Cal.~~

(E) The agreement shall include a process for resolving disagreements between the local educational agency and county mental health plan network related to any of the elements of the agreement described in this paragraph.

(F) The agreement shall include strategies to support the educational success of pupils who have repeated or prolonged absences from school due to mental illness or substance abuse disorders.

(10) A plan to establish a program described in this section in at least one school within the local educational agency in the first year and to expand the partnership to three additional schools within three years.

(b) The partnership shall participate in the performance outcome system established by the State Department of Health Care Services pursuant to Section 14707.5 to measure results of services provided under the partnership between the county mental health plan, or the qualified provider, and the local educational agency.

(c) For purposes of this section, "local educational agency" has the same meaning as that term is defined in Section 56026.3 of the Education Code.

(d) Where applicable, and to the extent mutually agreed to by a school district and a plan or insurer, it is the intent of the Legislature that a health care service plan or a health insurer be authorized to participate in the partnerships described in this part.

5921. (a) (1) The Mental Health Services Oversight and Accountability Commission, in consultation with the State Department of Education and the State Department of Health Care Services, shall develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the partnerships described in this part.

(2) The guidelines shall include provisions for integration with funds and services supplemented with funds from the Youth Education, Prevention, Early Intervention and Treatment Account, created pursuant to subdivision (f) of Section 34019 of the Revenue

and Taxation Code, to the extent that funds from that account are appropriated for purposes of this part.

~~(3) The guidelines shall include incentives for counties and local educational agencies to capture savings in reduced special education costs and reinvest those savings to expand the program to new schools each year with an expectation that funds from the Mental Health and Services Act and the Youth Education, Prevention, Early Intervention and Treatment Account, created pursuant to subdivision (f) of Section 34019 of the Revenue and Taxation Code, will only be required for the first three years of a program at each school.~~

(b) The State Department of Education shall develop guidelines for local educational agencies on the manner in which to enter into partnerships described in this part.

(c) The State Department of Health Care Services shall develop guidelines for county behavioral health departments on the manner in which to use funds from the Mental Health Services Fund and funds from the Medi-Cal program to enter into and support the partnerships described in this part.

5922. (a) The County and Local Educational Agency Partnership Fund is hereby created in the State Treasury. Moneys in the fund are available, upon appropriation by the Legislature, to the State Department of Education for the purpose of funding the partnerships described in this part. The State Department of Education shall fund partnerships described in this part through a competitive grant program. Priority in funding shall be given to partnerships with local educational agencies that have demonstrated high levels of childhood adversity, including, but not limited to, high-poverty local educational agencies and schools eligible under the Community Eligibility Provision of the Healthy, Hunger-Free Kids Act of 2010 (Public Law 111-296) and local educational agencies and schools identified in the California Longitudinal Pupil Achievement Data System as having high rates of foster youth and homeless children and youth.

(b) (1) For the 2018–19 fiscal year and each fiscal year thereafter, to the extent there is an appropriation in the annual Budget Act or another act made for purposes of this part, the Superintendent of Public Instruction shall allocate funds from that appropriation to the County and Local Educational Agency Partnership Fund.

(2) Other funds identified and appropriated by the Legislature may also be deposited into the County and Local Educational Agency Partnership Fund and used for the purposes specified in subdivision (a).

(c) Funds made available in the annual Budget Act for the purpose of providing educationally related mental health and substance use disorder services, including out-of-home residential services for emotionally disturbed pupils, *whether* required *or not* by an individualized education program, shall be used only for that purpose and shall not be deposited into the County and Local Educational Agency Partnership Fund. *Nothing in this subdivision shall require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this part.*

SEC. 3. It is the intent of the Legislature that, commencing with ~~fiscal year 2018–19,~~ *the 2018–19 fiscal year,* the State Department of Health Care Services utilize funds from the Youth Education, Prevention, Early Intervention and Treatment Account created pursuant to subdivision (f) of Section 34019 of the Revenue and Taxation Code to support the partnerships created pursuant to this act, and to allocate a portion of those funds only to counties that also provide funds from the Mental Health Services Fund and Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment mental health and substance use disorder funds for the purposes of this act.

O

SB 191 (Beall) – FACT SHEET
Addressing Mental Health and Substance Use in Schools

PROBLEM

According to the California Health Care Foundation, approximately 700,000 students—7.5 percent of all school-age children in California—have a serious behavioral health disorder, but only 120,000 receive therapy or counseling as part of their Individualized Education Program (IEP). A lack of coordinated, integrated approaches by counties and Local Education Agencies (LEAs) to address student mental health and substance use, particularly for those most deeply impacted by childhood adversity, despite the demonstrated need for services and the positive outcomes that these approaches promise, contributes to students' mental health needs not being met. Schools can reduce barriers to access for children and families, such as stigma, affordability, and problems recognizing symptoms, and provide maximal coverage for universal prevention and early intervention programs.

BACKGROUND

Student mental health and substance use problems are often manifestations of childhood trauma. Included among the numerous long-term negative health, social, and educational outcomes associated with childhood trauma are special health care needs; suicide attempts and depression; alcoholism and injection drug use; learning difficulties and delays on cognitive and social-emotional indicators; low school engagement and attendance problems; repeating and grade and academic failure; and bullying, dating violence, delinquent behavior, physical fighting, and weapon carrying.

The most effective interventions to address the impact of early adversity on negative outcomes for children are preventive measures and interventions provided universally within an integrated school-based mental health system, involving education, prevention, and intervention. Universal school-based programs that focus on building social, emotional, cognitive, and substance refusal skills have been shown to impact the initiation or escalation of substance use. The multi-tiered systems of supports (MTSS) model underlies many successful programs in California, and has demonstrated improvement in educational outcomes, including increasing school attendance and academic performance, and reducing school dropouts, high-end special education placements, and overall special education costs.

In 2011, California changed the way it funded educationally related mental health services, moving from a county-run system to a LEA-run system via AB 114. A 2015 audit found that LEAs and counties could benefit financially, and improve access to mental health and substance use services by collaborating to provide services to eligible students, such as the MTSS model. However, these partnerships are rarely implemented. In fact, only six out of 122 Special Education Local Plan Areas (SELPAs) are known to have agreements in place with a county mental health plan or qualified provider operating in the county health plan network.

THIS BILL

SB 191 uses financial incentives to promote partnerships in an effort to better serve children and obtain more federal funding by creating MTSS programs in schools to provide mental health and substance use prevention and early intervention services.

Specifically, SB 191:

1. Creates demonstration partnerships between School Districts/LEAs and County Mental Health Plans or a provider in the county mental health plan network to provide universal mental health and substance use supports, assessments and services;
2. Maximizes federal Early and Periodic Screening, Diagnosis, and Treatment (Medi-Cal) funds for mental health and substance use services in schools;
3. Leverages school and community resources to offer comprehensive multi-tiered interventions on a sustainable basis;
4. Coordinates service teams that consider referrals for services, oversee school-wide efforts, and use data-informed processes to identify struggling pupils who require early interventions;
5. Targets interventions for pupils with identified social-emotional, behavioral, and academic needs, such as Early Mental Health Initiative (EMHI) services, therapeutic group interventions, functional behavioral analysis and plan development, and targeted skill groups;
6. Requires the California Department of Education, the State Department of Health Care Services, and the Mental Health Services Oversight and Accountability Commission to work together to develop guidelines for these partnerships and directing the use of Mental Health Service Act

(MHSA), Medi-Cal, and Proposition 64 (Adult Use of Marijuana Act) funds; and

7. Prioritizes for funding partnerships with LEAs that have demonstrated high levels of childhood adversity.

SUPPORT

California Council of Community Behavioral Health Agencies (Sponsor)
Children Now (Sponsor)
Seneca Family of Agencies (Sponsor)
Alliance for Boys and Men of Color
California Academy of Child & Adolescent Psychiatry
American Academy of Pediatrics, California
California Coverage & Health Initiatives
California School Board Association
California School Nurses Organization
California State Parent Teacher Association
Center for Autism and Related Disorders
Center for Youth Wellness
Central Valley Affiliate of the California Association of School Psychologists
Children's Defense Fund-California
Children's Health Coverage Coalition
Hillsides
Lincoln
Los Angeles Trust for Children's Health
NAMI California
National Center for Youth Law
SIATech California
Steinberg Institute
The Children's Partnership
Time for Kids
United Ways of California
Western Center on Law & Poverty

FOR MORE INFORMATION

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SENATE COMMITTEE ON EDUCATION
Senator Benjamin Allen, Chair
2017 - 2018 Regular

Bill No: SB 191 **Hearing Date:** March 15, 2017
Author: Beall
Version: January 30, 2017
Urgency: No **Fiscal:** Yes
Consultant: Lenin Del Castillo

Subject: Pupil health: mental health and substance use disorder services

NOTE: This bill has been referred to the Committees on Education and Health. A "do pass" motion should include referral to the Committee on Health.

SUMMARY

This bill authorizes local educational agencies (LEAs) to enter into partnerships, as specified, with county mental health providers to create programs for the provision of mental health and substance use supports, assessments and services.

BACKGROUND

Existing law:

1) Establishes the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for eligible people under 21 years of age to provide periodic screenings to determine health care needs and based upon the identified health care need and diagnosis, treatment services are provided. Existing law provides that EPSDT services are to be administered through local county mental health plans under contract with the State Department of Health Care Services. (Welfare & Institutions Code § 14700, et seq.)

2) Establishes the School-based Early Mental Health Intervention and Prevention Services for Children Act (EMHI) and authorizes the Director of the Department of Mental Health, in consultation with the Superintendent of Public Instruction, to award matching grants to local educational agencies to pay the state share of the costs of providing school-based early mental health intervention and prevention services to eligible students, subject to the availability of funding each year. (WIC § 4370, et seq.)

3) Establishes the Primary Intervention Program, using EMHI funds, to provide school-based early detection and prevention of emotional, behavioral, and learning problems in students in kindergarten and grades 1-3, with services provided by child aides under the supervision of a school-based mental health professional. (WIC § 4343, et seq.)

4) Encourages schools, as comprehensive school safety plans are reviewed and updated, to include in school safety plans clear guidelines for the roles and responsibilities of mental health professionals, community intervention

professionals, school counselors, school resource officers, and police officers on school campus, if the school district uses these people. The guidelines may include primary strategies to create and maintain a positive school climate, promote school safety, and increase pupil achievement, and prioritize mental health and intervention services, restorative and transformative justice programs, and positive behavior interventions and support. (Education Code § 32282.1)

5) Provides that corrective action other than out-of-school suspension includes study teams, guidance teams, resource panel teams, or other intervention-related teams that assess the behavior, and develop and implement individualized plans to address the behavior in partnership with the pupil and his or her parents. (EC § 48900.5)

6) Requires that the individualized education team for each student with exceptional needs consider the use of positive behavioral interventions and supports for students whose behavior impedes his or her learning. (EC § 56341.1)

ANALYSIS

This bill:

1) Makes various findings and declarations regarding student mental health and substance use disorders and the use integrated models to improve student health and academic performance.

2) Provides that a county, or a qualified provider operating as part of the county mental health plan network that provides substance use disorder services, and a local educational agency (LEA) may enter into a partnership to create a program that, in addition to reflecting each school's specified culture and needs, includes all of the following:

   a) Leveraging of school and community resources to offer comprehensive multitiered interventions on a sustainable basis.

   b) An initial school climate assessment that includes information from multiple stakeholders, including school staff, pupils, and families, that is used to inform the selection of strategies and interventions that reflect the culture and goals of the school.

   c) A coordination of services team that considers referrals for services, oversees schoolwide efforts, and uses data-informed processes to identify struggling students who require early interventions.

   d) Whole school strategies that address school climate and universal pupil well-being, such as positive behavioral interventions and supports or the Olweus Bullying Prevention Program, as well as comprehensive professional development opportunities, that build the capacity of the entire school community to recognize and respond to the unique social-emotional, behavioral, and academic needs of pupils.

e) Targeted interventions for pupils with identified social-emotional, behavioral, and academic needs, such as a therapeutic group interventions, functional behavioral analysis and plan development, targeted skills groups, and eligible services specified by the School-Based Early Mental Health Intervention and Prevention Services Matching Grant Program, as specified.

f) Intensive services, such as wraparound, behavioral intervention, or one-on-one support, that can reduce the need for a student's referral to special education or placement in more restrictive, isolated settings.

g) Specific strategies and practices that ensure parent engagement with the school and provide parents with access to resources that support their children's educational success.

h) Utilization of designated governmental funds for eligible Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided to pupils enrolled in Medi-Cal for mental health and substance use disorder service costs, for non-Medi-Cal enrolled pupils with an individualized education program (IEP), and for pupils who do not have an IEP if the services are provided by a provider, as specified.

i) An agreement to establish a Medi-Cal mental health and substance use disorder provider that is county operated or county contracted for the provision of mental health and substance use disorder services to pupils of the local educational agency (LEA), as specified. The LEA, with permission of the pupil's parent, shall provide the county mental health plan provider with the information of the health insurance carrier for each pupil.

  i) The agreement shall address how to cover the costs of mental health and substance use disorder provider services not covered by funds, as specified, in the event that mental health and substance use disorder service costs exceed the agreed-upon funding outlined in the partnership agreement between the county mental health plan, or the qualified provider, and the LEA following a yearend cost reconciliation process, and in the event that the LEA does not elect to provide the services through other means.

  ii) The agreement shall fulfill reporting and all other requirements under state, federal and Medi-Cal EPSDT provisions, and measure the effect of the mental health and substance use disorder intervention and how that intervention meets the goals in a pupil's IEP or relevant plan for non-IEP pupils.

  iii) The agreement shall provide for on-campus services by clinicians who are part of commercial insurance health plan behavioral health networks at schools where a significant percentage of students are not enrolled in Medi-Cal.

j) A plan to establish a program, as specified, in at least one school within the local educational agency (LEA) in the first year and to expand the partnership to three additional schools within three years.

3) Provides that the partnership shall participate in the performance outcome system established by the State Department of Health Care Services, as specified, to measure results of services provided under the partnership between the county mental health plan, or the qualified provider, and the LEA.

4) Specifies that LEA has the same meaning as it is defined in Education Code § 56026.3.

5) Provides that where applicable, and to the extent mutually agreed to by a school district and a plan or insurer, it is the intent of the Legislature that a health care service plan or a health insurer be authorized to participate in the partnerships.

6) Requires the Mental Health Services Oversight and Accountability Commission, in consultation with the State Department of Education (SDE) and the State Department of Health Care Services, to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the partnerships.

   a) Provides that the guidelines shall include provisions for integrations with funds and services supplemented with funds from the Youth Education, Prevention, Early Intervention and Treatment Account, as specified, to the extent that funds from that account are appropriated for those purposes.

   b) Provides that the guidelines shall include incentives for counties and LEAs to capture savings in reduced special education costs and reinvest those savings to expand the program to new schools each year with an expectation that funds from the Mental Health and Services Act and the Youth Education, Prevention, Early Intervention and Treatment Account, as specified, will only be required for the first three years of a program at each school.

7) Requires the SDE to develop guidelines for LEAs on the manner in which to enter into partnerships.

8) Provides that the State Department of Health Care Services shall develop guidelines for county behavioral health departments on the manner in which to use funds from the Mental Health Services Fund and funds from the Medi-Cal program to enter into and support the partnerships.

9) Creates the County and Local Educational Agency Partnership Fund in the State Treasury, as specified, for the purpose of funding the partnerships, and requires the SDE to fund the partnerships through a competitive grant program. Priority in funding shall be given to partnerships with LEAs that have demonstrated high

levels of childhood adversity, as specified, and LEAs and schools identified as having high rates of foster youth and homeless children and youth.

10) Provides that to the extent there is an appropriation in the annual Budget Act or another act for this purpose, the Superintendent of Public Instruction shall allocate funds from that appropriation to the County and Local Educational Agency Partnership Fund.

11) Provides that other funds identified and appropriated by the Legislature may also be deposited in the County and Local Educational Agency Partnership Fund, and that funds made available in the annual Budget Act for the purpose of providing educationally related mental health and substance use disorder services, including out-of-home residential services for emotionally disturbed pupils, required by an individualized education program, shall be used only for that purpose and shall not be deposited into the County and Local Educational Agency Partnership Fund.

12) Specifies that it is the intent of the Legislature that, commencing with the 2018-19 fiscal year, the State Department of Health Care Services utilize funds from the Youth Education, Prevention, Early Intervention and Treatment Account, as specified, to support the partnerships and to allocate a portion of those funds only to counties that also provide funds from the Mental Health Services Fund and Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment mental health and substance use disorder funds for the purposes of this act.

STAFF COMMENTS

1) ***Need for the bill***. The author's office indicates that "according to the California Health Care Foundation, approximately 700,000 students—7.5 percent of all school-age children in California—have a serious behavioral health disorder, but only 120,000 receive therapy or counseling as part of their individualized education programs (IEPs). A lack of coordinated, integrated approaches by counties and local educational agencies (LEAs) to address student mental health and substance use, particularly for those most deeply impacted by childhood adversity, despite the demonstrated need for services and the positive outcomes that these approaches promise, contributes to students' mental health needs not being met. Schools can reduce barriers to access for children and families, such as stigma, affordability, and problems recognizing symptoms, and provide maximal coverage for universal prevention and early intervention programs."

   This measure is intended to promote partnerships in an effort to better serve children in providing mental health and substance use prevention and early intervention services.

2) ***Provision of mental health services***. The federal Individuals with Disabilities Education Act provides that students with exceptional needs identified as having "emotional disturbance" may be eligible to receive mental health services. Mental health services are considered "related services" and include counseling, psychological services, parent counseling and training, and residential

placement, among others. (United States Code, Title 20, § 1400, et seq. and Code of Federation Regulations, Title 34, § 300.34)

AB 114 (Committee on Budget, Chapter 43, Statutes of 2011) shifted responsibility for mental health services for students from counties to local educational agency (LEAs). Any and all services identified in a student's individualized education program (IEP) must be provided, whether directly by LEA employees or through contract with outside providers such as county mental health agencies. LEAs are required to ensure services are provided to students regardless of who provides or pays for those services.
(Education Code § 56139)

3) ***Recent State audit and EPSDT.*** The Bureau of State Audits released a report in January 2016, titled *Student Mental Health Services: Some Students' Services Were Affected by a New State Law, and the State Needs to Analyze Student Outcomes and Track Service Costs*. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which is a Medi-Cal benefit for people under the age of 21 who have "full-scope" Medi-Cal eligibility, provides eligible children access to a range of mental health services that include, among other things, mental health assessment, mental health services, therapy, rehabilitation, therapeutic behavioral services, crisis intervention/stabilization, day rehabilitation/day treatment, medication support and case management. EPSDT services are administered through county mental health plans under contract with the California Department of Health Care Services; LEAs may provide and bill for EPSDT mental health services only pursuant to a contract with the county mental health plan (either the county mental health plan provides and bills for the service, or the LEA becomes a certified provider via the county mental health plan and the LEA provides and bills for the service).

   The audit noted that although LEAs cannot access funding for EPSDT services unless they contract with their respective counties, such collaborations could financially benefit both counties and LEAs and increase the provision of services to children. This audit recommended that the Legislature *require* counties to enter into agreements with special education local plan areas (SELPAs) to allow SELPAs and their LEAs to access EPSDT funding through the county mental health programs by providing EPSDT mental health services.

4) ***Partnerships.*** According to the recent State audit, the Children's Center at Desert Mountain SELPA's collaboration with San Bernardino County is financially beneficial for both the SELPA and the county. The SELPA contributes a portion of San Bernardino's match of federal reimbursements, saving the county funds that it would otherwise have to contribute as the local entity. Under the terms of its agreement with San Bernardino, Desert Mountain was able to access approximately $4 million in federal EPSDT funds to provide mental health services in fiscal year 2014–15. This arrangement enables Desert Mountain to provide mental health services to Medi-Cal-eligible students with and without individualized education program (IEPs). The State audit also describes a contractual agreement between Mt. Diablo Unified School District and the county mental health department for Mt. Diablo to receive Medi-Cal funds as a provider of EPSDT services to Medi-Cal-eligible students.

This bill establishes a framework for partnerships and authorizes counties and LEAs to enter into such partnerships. *The Committee may wish to consider whether such statutory authority is necessary*, as the Education Code is permissive and the examples of existing partnerships described above demonstrates that such partnerships may exist without explicit language in statute.

5) ***Responsibility for costs.*** This bill requires partnerships to include provisions for local educational agencies (LEAs) to address how to cover the costs of providing mental health services in specific situations. *The Committee may wish to consider* whether to endorse the formation of partnerships that pre-determine fiscal decisions that may be best left to the local partners.

6) ***Multi-tiered interventions***. Many schools voluntarily follow models of tiered interventions to address student needs prior to imposing discipline or making referrals to special education. Models include Schoolwide Positive Behavior Interventions and Supports, Response to Intervention and Positive Environments, Network of Trainers. Typically, the base tier is a schoolwide approach involving instruction, school climate, etc. The middle tier is targeted to students who did not respond to the schoolwide efforts and involved more intense interventions such as tutoring. The top tier focuses on a smaller group of students who continue to need support and may include very intense and frequent services such as counseling.

   The Student Success Team, formerly Student Study Team, is a positive schoolwide early identification and intervention process. Working as a team, the student, parent, teacher and school administrator identify the student's strengths and assets upon which an improvement plan can be designed. As a regular school process, the team intervenes with school and community support and an improvement plan that all team members agree to follow. Follow-up meetings are planned to provide a continuous casework management strategy to ensure the needs of students are met.

7) ***Role for the Senate Health Committee.*** This bill has been double-referred to the Senate Health Committee as it contains provisions within the jurisdiction of that Committee. It is presumed that the Senate Health Committee analysis will address those relevant provisions, such as the requirement for partnership agreements to include the utilization of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program funds for mental health and substance use disorder services costs, for non-Medi-Cal enrolled pupils with individualized education programs (IEPs), and pupils who do not have IEPs, as specified, and whether this requirement potentially expands the scope of the use of EPSDT funds.

8) ***Previous legislation***. SB 1113 (Beall, 2016) authorized LEAs to enter into partnerships, as specified, with county mental health plans for the provisions of EPSDT mental health services, and to expand the allowable uses of specified mental health funds. SB 1113 was vetoed by the Governor, whose veto message read:

> ***I am returning the following four bills without my signature:***
>
> ***Assembly Bill 1198***
> ***Assembly Bill 1783***
> ***Assembly Bill 2182***
> ***Senate Bill 1113***
>
> ***Each of these bills creates unfunded new programs.***
>
> ***Despite significant funding increases for local educational agencies over the past few years, the Local Control Funding Formula remains only 96 percent funded. Given the precarious balance of the state budget, establishing new programs with the expectation of funding in the future is counterproductive to the Administration's efforts to sustain a balanced budget and to fully fund the Local Control Funding Formula.***
>
> ***Additional spending to support new programs must be considered in the annual budget process.***

AB 1644 (Bonta, 2016) required the Department of Public Health (DPH) to establish a four-year program to support local decisions to provide funding for early mental health support services, requires DPH to provide technical assistance to local educational agencies, and requires DPH to select and support schoolsites to participate in the program. AB 1644 was held in the Senate Appropriations Committee.

AB 1133 (Achadjian, 2015) established a four-year pilot program, the School-Based Early Mental Health Intervention and Prevention Services Support Program (EMHI Support Program), to provide outreach, free regional training, and technical assistance for local educational agencies in providing mental health services at school sites. AB 1133 was held in the Assembly Appropriations Committee.

AB 1025 (Thurmond, 2015) required the State Department of Education (SDE) to establish a three-year pilot program in school districts to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multi-tiered framework. AB 1025 was held in the Senate Appropriations Committee.

AB 1018 (Cooper, 2015) required the Department of Health Care Services and SDE to convene a joint taskforce to examine the delivery of mental health services to children. AB 1018 was held in the Senate Appropriations Committee.

AB 580 (O'Donnell, 2015) required the SDE to develop model referral protocols for voluntary use by schools to address the appropriate and timely referral by school staff of students with mental health concerns. AB 580 was vetoed by the

Governor, whose veto message read:

> ***California does not currently have specific model referral protocols for addressing student mental health as outlined by this bill. However, the California Department of Education recently received a grant from the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration to identify and address critical student and family mental health needs.***
>
> ***It's premature to impose an additional and overly prescriptive requirement until the current efforts are completed and we can strategically target resources to best address student mental health.***

SUPPORT

Alliance for Boys and Men of Color
American Academy of Pediatrics, California
California Council of Community Behavioral Health Agencies
California School Nurses Organization
California State PTA
Central Valley Affiliate of the California Association of School Psychologists
Children's Defense Fund—California
Children's Health Coverage Coalition
Los Angeles Trust for Children's Health
Seneca Family of Agencies
SIATech
Southeast Asia Resource Action
Steinberg Institute
United Ways of California
Western Center on Law and Poverty

OPPOSITION

None received.

-- END --

SENATE COMMITTEE ON HEALTH

Senator Ed Hernandez, O.D., Chair

BILL NO: SB 191
AUTHOR: Beall
VERSION: March 28, 2017
HEARING DATE: April 5, 2017
CONSULTANT: Reyes Diaz

SUBJECT: Pupil health: mental health and substance use disorder services

SUMMARY: Allows a county or a qualified provider, as specified, and a local educational agency to enter into a partnership to create a program, as specified, that targets pupils with mental health and substance use disorders. Creates the County and Local Educational Agency Partnership Fund from which moneys will be made available, as specified, to fund the partnerships. Requires specified entities to develop guidelines on how to enter into the described partnerships. Gives preference for funding to partnerships that maximize and use existing specified funds to support the partnerships.

Existing law:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income persons receive health care benefits.

2) Establishes, under the terms of a federal Medicaid waiver, a managed care program providing Medi-Cal specialty mental health services for eligible low-income persons administered through local county mental health plans under contract with DHCS.

3) Establishes the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for eligible people under 21 years of age to provide periodic screenings to determine health care needs, and based upon the identified health care need and diagnosis, treatment services are provided. Requires EPSDT services to be administered through local county mental health plans under contract with the DHCS.

4) Defines "local educational agency" (LEA) as a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area.

5) Defines the scope of covered services that an LEA may provide for children with an individualized education plan (IEP) or an individualized family service plan (IFSP).

6) Requires that specified services provided by a LEA are Medi-Cal benefits, to the extent federal financial participation (FFP) is available, are subject to utilization controls and standards adopted by DHCS, and are consistent with Medi-Cal requirements for physician prescription, order, and supervision.

7) Requires county mental health plans to provide specialty mental health services to eligible Medi-Cal beneficiaries, including both adults and children. Includes EPSDT within the scope of specialty mental health services for eligible Medi-Cal beneficiaries under the age of 21 pursuant to federal Medicaid law.

8) Establishes the School-based Early Mental Health Intervention and Prevention Services for Children Act (EMHI) and authorizes the Director of the Department of Mental Health, in consultation with the Superintendent of Public Instruction, to award matching grants to local educational agencies to pay the state share of the costs of providing school-based early mental health intervention and prevention services to eligible students, subject to the availability of funding each year.

9) Establishes the Primary Intervention Program, using EMHI funds, to provide school-based early detection and prevention of emotional, behavioral, and learning problems in students in kindergarten and grades 1-3, with services provided by child aides under the supervision of a school-based mental health professional.

10) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, which provides funds to counties to expand services, and develop innovative programs and integrated service plans, for mentally ill children, adults, and seniors through a one percent income tax on personal income above $1 million.

11) Requires DHCS, in collaboration with the California Health and Human Services Agency (CHHS), and in consultation with the MHSOAC, to create a plan for a performance outcome system for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under the age of 21.

12) Creates the Youth Education, Prevention, Early Intervention and Treatment Account, pursuant to the 2016 ballot initiative, the “Control, Regulate, and Tax Adult Use of Marijuana Act,” or Proposition 64, to be administered by DHCS for programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance abuse.

This bill:

1) Allows a county, or a qualified provider operating as part of the county mental health plan network that provides substance use disorder services, and a LEA to enter into a partnership to create a program that, in addition to reflecting each school’s specified culture and needs, includes all of the following:

    a) Leveraging of school and community resources to offer comprehensive multitiered interventions on a sustainable basis;
    b) An initial school climate assessment that includes information from multiple specified stakeholders that is used to inform the selection of strategies and interventions that reflect the culture and goals of the school;
    c) A coordination of services team that considers referrals for services, oversees schoolwide efforts, and uses data-informed processes to identify struggling pupils who require early interventions;
    d) Whole school strategies that address school climate and universal pupil well-being, as specified;
    e) Targeted interventions for pupils with identified social-emotional, behavioral, and academic needs, as specified;
    f) Intensive services, as specified, that can reduce the need to a pupil’s referral to special education or placement in more restrictive, isolated settings;

g) Specified strategies and practices that ensure parent engagement with the school, as specified;
h) Utilization of designated governmental funds, as specified; and
i) An agreement between the county mental health plan, or the qualified provider, and a LEA that establishes a Medi-Cal mental health provider that is county operated or county contracted for the provision of mental health and substance use disorder services to pupils of the LEA. Allows the agreement to include the provision of campus-based services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an IEP, as specified, and pupils who do not have an IEP but who a teacher believes may require such services and, with parental consent, to provide services to those pupils.

    i. Requires an LEA, with the permission of the pupil's parent, to provide the county mental health plan provider with the information of the health insurance carrier for each pupil.
    ii. Requires an agreement to address how to cover the costs of mental health and substance use disorder provider services not covered by specified government funds in the event costs exceed the agree-upon funding outlined in the partnership agreement, as specified. Prohibits an LEA from being held liable for any costs that exceed the agreed-upon funding in the partnership agreement.
    iii. Requires the agreement to fulfill reporting and all other requirements under state and federal Individuals with Disabilities Education Act (IDEA) and EPSDT provisions, and measure the effect of mental health and substance use disorder intervention, as specified.
    iv. Requires the agreement to include a process for resolving disagreements between the LEA and the county mental health plan network, as specified.
    v. Requires an agreement to include strategies to support educational success of pupils that have repeated or prolonged absences from school due to mental illness or substance use disorders.

j) A plan to establish a program set forth by the provisions in this bill in at least one school within the LEA in the first year and to expand the partnership to three additional schools within three years.

2) Requires a partnership, as specified, to participate in the EPSDT performance outcome system established by DHCS to measure results of services provided through the partnership.

3) Requires the MHSOAC, in consultation with the California Department of Education (CDE) and DHCS, to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the partnerships. Requires the guidelines to include provisions for integration with funds and services supplemented with funds from the Youth Education, Prevention, Early Intervention and Treatment Account, as specified, to the extent funds from the account are appropriated for purposes described by provisions of this bill.

4) Requires CDE to develop guidelines for LEAs on how to enter into the described partnerships.

5) Requires DHCS to develop guidelines for county behavioral health departments on how to use funds from the Mental Health Services Fund and from the Medi-Cal program to enter into and support the described partnerships.

6) Creates the County and Local Educational Agency Partnership Fund in the State Treasury from which moneys will be made available, upon appropriation of the Legislature, to CDE for the purpose of funding the described partnerships through a competitive grant program. Requires priority in funding to be given to partnerships with LEAs that have demonstrated high levels of childhood adversity, as specified.

7) Requires CDE, for Fiscal Year 2018-19 and each fiscal year thereafter, as specified, to allocate funds to the County and Local Educational Agency Partnership Fund. Allows other funds identified and appropriated by the Legislature to also be deposited into this fund.

8) Requires funds made available in the annual Budget Act for purposes of providing educationally related mental health and substance use disorder services, as specified, whether required or not by an IEP to be used only for that purpose, and prohibits those funds from being deposited into the County and Local Educational Agency Partnership Fund.

9) Declares the intent of the Legislature that where applicable, and to the extent mutually agreed to by a school district and a plan or insurer, a health care service plan or a health insurer to be authorized to participate in the partnerships set forth by this bill.

10) Declares the intent of the Legislature that commencing with Fiscal Year 2018-19 DHCS use funds from the Youth Education, Prevention, Early Intervention and Treatment Account to support the partnerships created pursuant to this bill and to allocate a portion of those funds only to counties that also provide funds from the Mental Health Services Fund and EPSDT mental health and substance use disorder funds.

11) Makes declarations and findings related to student mental health and substance use disorder problems, as well as the issues that individuals who have experienced adverse childhood experiences are more likely to face, including substance abuse.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, the California Health Care Foundation reports approximately 700,000 students (7.5% of all school-age children in California) have a serious behavioral health disorder, but only 120,000 receive therapy or counseling as part of their Individualized Education Program (IEP). A lack of coordinated, integrated approaches by counties and Local Education Agencies (LEAs) to address student mental health and substance use disorders, particularly for those most deeply impacted by childhood adversity, despite the demonstrated need for services and the positive outcomes that these approaches promise, contributes to students' mental health needs not being met. Schools can reduce barriers to access for children and families, such as stigma, affordability, and problems recognizing symptoms, and provide maximal coverage for universal prevention and early intervention programs.

2) *Background.* The federal IDEA provides that students with exceptional needs identified as having emotional disturbance may be eligible to receive mental health services, which are considered related services and include counseling, psychological services, parent counseling and training, and residential placement, among others. Prior to 2012, a student with exceptional needs, who also had mental health needs and services documented in their IEP, was referred by the LEAs to county mental health agencies for treatment, pursuant to AB 3632 (Brown, Chapter 26, Statutes of 1984). AB 114 (Committee on Budget Chapter 43, Statutes of 2011) shifted responsibility for providing and funding IDEA-related mental health services from county mental health agencies to LEAs (the Superintendent of Public Instruction is responsible for monitoring LEAs to ensure compliance). Any and all services identified in a student's IEP must be provided, whether directly by LEA employees or through contract with outside providers, such as county mental health agencies. LEAs are required to ensure services are provided to students regardless of who provides or pays for those services.

   The EPSDT program is a Medi-Cal benefit for people under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs and, based upon the identified health care need and diagnosis, treatment services are provided. EPSDT services include all services otherwise covered by Medi-Cal, and EPSDT beneficiaries can receive additional medically necessary services. EPSDT provides eligible children access to a range of mental health services that include, among other things, mental health assessment, mental health services, therapy, rehabilitation, therapeutic behavioral services, crisis intervention/stabilization, day rehabilitation/day treatment, medication support, and case management.

   LEAs are responsible for educationally necessary mental health services that are identified in a student's IEP, but are prohibited from directly providing or billing for EPSDT services unless the county mental health department chooses to contract with the LEA for those services (EPSDT is considered specialty mental health). LEAs are required to ensure services identified in a student's IEP are provided, regardless of whether the county directly provides services, denies services, or reimburses the school for any costs if the LEA provides services (in cases where the LEA provides services covered under general Medi-Cal that overlap with EPSDT services).

   According to CDE, LEAs may use one or more of the following options for sourcing mental health services to Medi-Cal eligible students (including EPSDT and other mental health services):

   a) Provide and pay for services without seeking Medi-Cal reimbursement;
   b) Use the LEA Medi-Cal Billing Option Program. Through this program, the LEA employs or contracts with qualified practitioners to provide the services pursuant to the IEP, pays for the services, and submits a claim for reimbursement. In order to use this option, the LEA must meet a number of administrative conditions, including enrollment as a Medi-Cal provider; and,
   c) For EPSDT services, collaborate with county mental health departments to secure the specialty mental health services through the county mental health plan. There are two ways an LEA can secure these services:

      i. Enter into a contract or Memorandum of Understanding with the mental health plan for a specialty mental health service or an array of specialty mental health services. In this case, county mental health plans provide

the service and incur the cost, and bill Medi-Cal for federal reimbursement; or,

ii. Request to be a certified provider of Medi-Cal specialty mental health services from the county mental health plan. If the county mental health plan certifies the LEA as an organizational provider, the LEA would provide the specialty mental health service through an LEA qualified employee and submit a claim to the county mental health plan for reimbursement.

3) *Student Mental Health Services Audit.* In January 2016, the California State Auditor released report 2015-112 which reviewed the effect of AB 114 of mental health services provided to pupils through IEPs. Among the findings are: 1) The mental health services and providers did not change at the four programs reviewed; 2) In some cases LEAs removed mental health services from student IEPs because of AB 114 and for other students, the LEAs could not explain why services were removed; 3) CDE has not performed an analysis of the education outcomes to determine if pupil outcomes have improved; 4) CDE does not require LEAs to track total expenditures for mental health services; 5) None of the four LEAs could determine their total costs to provide mental health services; and, 6) Only one of the four LEAs has contracted with its county to access certain funding for mental health services through Medi-Cal. The audit recommends the Legislature should require CDE to report annually regarding the outcomes for students receiving mental health services relative to key performance indicators; and, require counties to enter into agreements with SELPAs to allow SELPAs and their LEAs to access EPSDT funding through county mental health programs by providing EPSDT mental health services.

4) *DHCS Performance Outcome System.* The performance outcome system for EPSDT mental health services is intended to improve outcomes at the individual, program, and system levels and inform fiscal decision-making related to the purchase of services, and is part of the reporting effort for the implementation of a performance outcome system for Medi-Cal specialty mental health services for children and youth. Since 2012, DHCS has worked with several groups to create a structure for reporting, develop the Performance Measurement Paradigm, and develop indicators and measures. The performance outcome system will be used to evaluate the domains of access, engagement, service appropriateness to need, service effectiveness, linkages, cost effectiveness and satisfaction. Three reports will be provided: statewide aggregate data; population-based county groups, and county-specific data. Initial reports have been released in 2015.

5) *Proposition 64.* In November 2016, voters passed the Control, Regulate, and Tax Adult Use of Marijuana Act, which, among other things, allocates 60% of taxes on marijuana, by July 15 of each fiscal year beginning in Fiscal Year 2018-19, to the Youth Education, Prevention, Early Intervention and Treatment Account to be administered by DHCS, as specified, for programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance abuse. Proposition 64 contains a provision that prohibits the Legislature, prior to July 1, 2028, from changing this allocation to DHCS for its stated purposes.

6) *Double referral.* This bill was heard in the Senate Education Committee on March 15, 2017, and passed out on a vote of 7-0.

7) *Prior legislation.* SB 1113 (Beall of 2016) authorized LEAs to enter into partnerships, as specified, with county mental health plans for the provision of EPSDT mental health services, and to expand the allowable uses of specified mental health funds. *SB 1113 was vetoed by the Governor, whose veto message stated that the bill created an unfunded new program, and given the precarious balance of the state budget, establishing new programs with the expectation of funding in the future is counterproductive to the Administration's efforts to sustain a balanced budget and to fully fund the Local Control Funding Formula. The Governor further stated that additional spending to support new programs must be considered in the annual budget process.*

   AB 1018 (Cooper of 2015) would have required DHCS and CDE to convene a joint taskforce to examine the delivery of mental health services to children. *AB 1018 was held in the Senate Appropriations Committee.*

   SB 276 (Wolk, Chapter 653, Statutes of 2015) requires DHCS to seek federal financial participation for covered services that are provided by a LEA to a child who is an eligible Medi-Cal beneficiary, regardless of whether the child has an IEP or an individualized family service plan, or whether those same services are provided at no charge to the beneficiary or to the community at large, if the LEA takes all reasonable measures to ascertain and pursue claims for payment of covered services against legally liable third parties.

   AB 1644 (Bonta of 2016) would have required the Department of Public Health (DPH) to establish a four-year program to support local decisions to provide funding for early mental health support services, required DPH to provide technical assistance to local educational agencies, and required DPH to select and support school sites to participate in the program. *AB 1644 was held in the Senate Appropriations Committee.*

   AB 1133 (Achadjian of 2015) would have established a four-year pilot program, the School-Based Early Mental Health Intervention and Prevention Services Support Program (EMHI Support Program), to provide outreach, free regional training, and technical assistance for LEAs in providing mental health services at school sites. *AB 1133 was held in the Assembly Appropriations Committee.*

   AB 1025 (Thurmond of 2015) would have required CDE to establish a three-year pilot program in school districts to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multi-tiered framework. *AB 1025 was held in the Senate Appropriations Committee.*

   AB 1018 (Cooper of 2015) would have required DHCS and CDE to convene a joint taskforce to examine the delivery of mental health services to children. *AB 1018 was held in the Senate Appropriations Committee.*

   AB 580 (O'Donnell of 2015) would have required CDE to develop model referral protocols for voluntary use by schools to address the appropriate and timely referral by school staff of students with mental health concerns. *AB 580 was vetoed by the Governor, whose veto message stated that California does not currently have specific model referral protocols for addressing student mental health as outlined by the bill; however, the California Department of Education recently received a grant from the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration to identify and address critical student and family mental health needs. The Governor further stated that it's*

premature to impose an additional and overly prescriptive requirement until the current efforts are completed and the state can strategically target resources to best address student mental health.

SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012) requires DHCS, in collaboration with CHHS, and in consultation with the MHSOAC and a stakeholder advisory committee to develop a plan for a performance outcomes system for EPSDT specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. The purpose of the system is to improve beneficiary outcomes and inform decisions regarding the purchase of services.

AB 2608 (Bonilla, Chapter 755, Statutes of 2012) made permanent and expanded provisions relating to program improvement activities in the Medi-Cal Local Billing Option program, through which LEAs can draw down federal funding for health care services provided to Medi-Cal-eligible students. AB 2608 also expanded the scope of transportation services for which Medicaid reimbursements can receive reimbursement.

AB 114 (Committee on Budget) shifted responsibility for mental health services for students from counties to LEAs.

AB 3632 (Brown) required the referral of student with exceptional needs, who also had mental health needs and services documented in their IEP, by LEAs to county mental health agencies for treatment.

8) *Support.* Supporters of this bill, largely providers and consumer advocates, argue that this bill uses financial incentives to promote partnerships between counties and school districts in an effort to better serve children and to obtain more federal funding by creating sustainable multitiered systems of support. Supporters argue that a lack of coordinated, integrated approaches by counties and LEAs to address student mental health and substance use disorders contributes to students' mental health needs not being met. Supporters further argue that schools can reduce barriers to access for children and families, such as stigma, affordability, and problems recognizing symptoms, and provide maximal coverage for universal prevention and early intervention programs. NAMI California states that National Institute on Mental Health statistics show for 2016 among children aged 8-15 who needed mental health treatment only half (50.6%) received services in the previous year.

SUPPORT AND OPPOSITION:

Support: Alliance for Boys and Men of Color
California Access Coalition
California Council of Community Behavioral Health Agencies
California School Boards Association
California School Nurses Organization
California State PTA
Center for Autism and Related Disorders
Center for Youth Wellness
Children Now
Children's Defense Fund California
Hillsides
Lincoln
NAMI California

National Center for Youth Law
Seneca Family of Agencies
SIATech California
Steinberg Institute
Time for Kids, Inc.
United Way
Western Center on Law and Poverty

Oppose: None received

-- END --

AGENDA ITEM 2

Action

April 27, 2017 Commission Meeting

Senate Bill 192: Mental Health Services Act Reversion Fund

Summary: Carla Suporta, Legislative Consultant, from Senator Beall's Office will provide background and overview on Senate Bill 192 (Beall). This bill, as currently drafted, establishes the Mental Health Services Act Reversion Fund into which reverted unspent funds, will be deposited for allocation, by the Legislature, to counties to expand capacity for services and supports to address unmet community needs. The bill requires annual reporting to the Legislature about the funds, as well as recommendations to the Legislature from the Commission and other entities on the allocation of the funds.

Presenter: Carla Saporta, Legislative Consultant, Senator Beall's Office

Enclosures: Senate Bill 192; SB 192 Fact Sheet; Senate Committee on Health Analysis.

Handout: None

Recommended Action: Staff requests direction from the Commission regarding Senate Bill 192.

AMENDED IN SENATE APRIL 18, 2017

AMENDED IN SENATE MARCH 28, 2017

SENATE BILL No. 192

Introduced by Senator Beall

January 30, 2017

An act to amend Sections 5891, 5892, and 5892.5 of, and to add Section 5892.3 to, the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 192, as amended, Beall. Mental Health Services Act Reversion Fund.

Existing law, the Mental Health Services Act (the MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs by imposing a tax of 1% on incomes above $1,000,000. Existing law requires the State Department of Health Care Services, among other things, to implement specified mental health services through contracts with county mental health programs or counties acting jointly. The MHSA establishes the Mental Health Services Oversight and Accountability Commission to oversee various parts of the act, as specified.

Under the MHSA, funds are distributed to counties for local assistance for designated mental health programs according to a specified county plan. The MHSA, except as specified, requires any funds allocated to a county that have not been spent for their authorized purpose within 3 years to revert to the state to be deposited into the fund and available for other counties in future years. The MHSA permits amendment by

the Legislature by a ⅔ vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA, and also permits the Legislature to add provisions to clarify procedures and terms of the MHSA by a majority vote.

This bill would amend the MHSA by instead requiring that any funds allocated since the 2008–09 fiscal year, except as specified, to a large, medium, small, or very small county, as defined, that have not been spent for their authorized purpose within 3 years of being allocated, and any interest earned on unspent funds, revert to the state for deposit into the newly established Mental Health Services Act Reversion Fund. The bill would authorize a very small county to apply for a waiver, subject to approval by the commission, requesting a delay of the reversion of funds, but not for more than 5 fiscal years from the time of allocation of funds. The bill would require the state to distribute the reverted funds to counties, or counties acting jointly, to fund prevention and early intervention or ~~innovative programs for youth~~ *innovation programs* that are consistent with mental health funding priorities ~~for youth~~ established by the Legislature and the ~~Mental Health Services Act,~~ *MHSA,* as specified. The bill would make the amount of funds available to counties in any fiscal year subject to an annual appropriation by the Legislature in the annual Budget Act.

~~This bill would require funding to be directed only to counties, or counties acting jointly, that provide evidence-based intervention services and supports for prevention, early detection, and treatment of psychosis, mood disorders, or other mental health issues for youth, as specified, and would require the counties~~ *This bill would require the counties, or counties jointly,* seeking funding to demonstrate to the commission that funding will be used to create, or expand the capacity for, ~~those services and supports.~~ *services and supports to address unmet community needs.* The bill would impose certain restrictions on eligibility for subsequent funding for counties that previously have been allocated funds. The bill would authorize the Legislature to give specific consideration to very small counties and small counties when making an appropriation from the Mental Health Services Act Reversion Fund.

This bill would require the commission to submit to the Legislature an annual report of its recommendations for recipients of funding and the amount of funding for each recipient in a manner that ensures that allocation of funds results in specified outcomes and to take into account certain criteria when recommending recipients and amounts of funding. The bill would also require the commission to require participating

counties to submit outcome data within one year of receiving funding, and would require the commission to aggregate and report the outcome data to the Legislature, as specified. The bill would require the department to annually report to the Legislature and the commission the amount of funds that are subject to reversion and the interest earned by counties, and to update necessary regulations, processes, and guidance to allow counties to revise or correct their annual revenue and expenditure reports.

This bill would also make conforming changes to related provisions.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 5891 of the Welfare and Institutions Code
2 is amended to read:
3 5891. (a) The funding established pursuant to this act shall be
4 utilized to expand mental health services. Except as provided in
5 subdivision (i) of Section 5892 due to the state's fiscal crisis, these
6 funds shall not be used to supplant existing state or county funds
7 utilized to provide mental health services. The state shall continue
8 to provide financial support for mental health programs with not
9 less than the same entitlements, amounts of allocations from the
10 General Fund or from the Local Revenue Fund 2011 in the State
11 Treasury, and formula distributions of dedicated funds as provided
12 in the last fiscal year which ended prior to the effective date of
13 this act. The state shall not make any change to the structure of
14 financing mental health services, which increases a county's share
15 of costs or financial risk for mental health services unless the state
16 includes adequate funding to fully compensate for such increased
17 costs or financial risk. These funds shall only be used to pay for
18 the programs authorized in Sections 5890 and 5892. These funds
19 may not be used to pay for any other program. These funds may
20 not be loaned to the General Fund or any other fund of the state,
21 or a county general fund or any other county fund for any purpose
22 other than those authorized by Sections 5890 and 5892.
23 (b) (1) Notwithstanding subdivision (a), and except as provided
24 in paragraph (2), the Controller may use the funds created pursuant
25 to this part for loans to the General Fund as provided in Sections
26 16310 and 16381 of the Government Code. Any such loan shall

be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (f) of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

SEC. 2. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the

1 County Behavioral Health Directors Association of California to
2 implement plans developed pursuant to Section 5847.
3 (3) Twenty percent of funds distributed to the counties pursuant
4 to subdivision (c) of Section 5891 shall be used for prevention and
5 early intervention programs in accordance with Part 3.6
6 (commencing with Section 5840).
7 (4) The expenditure for prevention and early intervention may
8 be increased in any county in which the department determines
9 that the increase will decrease the need and cost for additional
10 services to severely mentally ill persons in that county by an
11 amount at least commensurate with the proposed increase.
12 (5) The balance of funds shall be distributed to county mental
13 health programs for services to persons with severe mental illnesses
14 pursuant to Part 4 (commencing with Section 5850) for the
15 children's system of care and Part 3 (commencing with Section
16 5800) for the adult and older adult system of care.
17 (6) Five percent of the total funding for each county mental
18 health program for Part 3 (commencing with Section 5800), Part
19 3.6 (commencing with Section 5840), and Part 4 (commencing
20 with Section 5850), shall be utilized for innovative programs in
21 accordance with Sections 5830, 5847, and 5848.
22 (b) In any fiscal year after the 2007–08 fiscal year, programs
23 for services pursuant to Part 3 (commencing with Section 5800)
24 and Part 4 (commencing with Section 5850) may include funds
25 for technological needs and capital facilities, human resource
26 needs, and a prudent reserve to ensure services do not have to be
27 significantly reduced in years in which revenues are below the
28 average of previous years. The total allocation for purposes
29 authorized by this subdivision shall not exceed 20 percent of the
30 average amount of funds allocated to that county for the previous
31 five fiscal years pursuant to this section.
32 (c) The allocations pursuant to subdivisions (a) and (b) shall
33 include funding for annual planning costs pursuant to Section 5848.
34 The total of these costs shall not exceed 5 percent of the total of
35 annual revenues received for the fund. The planning costs shall
36 include funds for county mental health programs to pay for the
37 costs of consumers, family members, and other stakeholders to
38 participate in the planning process and for the planning and
39 implementation required for private provider contracts to be
40 significantly expanded to provide additional services pursuant to

1 Part 3 (commencing with Section 5800) and Part 4 (commencing
2 with Section 5850).
3 (d) Prior to making the allocations pursuant to subdivisions (a),
4 (b), and (c), funds shall be reserved for the costs for the State
5 Department of Health Care Services, the California Mental Health
6 Planning Council, the Office of Statewide Health Planning and
7 Development, the Mental Health Services Oversight and
8 Accountability Commission, the State Department of Public Health,
9 and any other state agency to implement all duties pursuant to the
10 programs set forth in this section. These costs shall not exceed 5
11 percent of the total of annual revenues received for the fund. The
12 administrative costs shall include funds to assist consumers and
13 family members to ensure the appropriate state and county agencies
14 give full consideration to concerns about quality, structure of
15 service delivery, or access to services. The amounts allocated for
16 administration shall include amounts sufficient to ensure adequate
17 research and evaluation regarding the effectiveness of services
18 being provided and achievement of the outcome measures set forth
19 in Part 3 (commencing with Section 5800), Part 3.6 (commencing
20 with Section 5840), and Part 4 (commencing with Section 5850).
21 The amount of funds available for the purposes of this subdivision
22 in any fiscal year is subject to appropriation in the annual Budget
23 Act.
24 (e) In the 2004–05 fiscal year, funds shall be allocated as
25 follows:
26 (1) Forty-five percent for education and training pursuant to
27 Part 3.1 (commencing with Section 5820).
28 (2) Forty-five percent for capital facilities and technology needs
29 in the manner specified by paragraph (2) of subdivision (a).
30 (3) Five percent for local planning in the manner specified in
31 subdivision (c).
32 (4) Five percent for state implementation in the manner specified
33 in subdivision (d).
34 (f) Each county shall place all funds received from the State
35 Mental Health Services Fund in a local Mental Health Services
36 Fund. The Local Mental Health Services Fund balance shall be
37 invested consistent with other county funds and the interest earned
38 on the investments shall be transferred into the fund. The earnings
39 on investment of these funds shall be available for distribution
40 from the fund in future fiscal years.

1 (g) All expenditures for county mental health programs shall
2 be consistent with a currently approved plan or update pursuant
3 to Section 5847.
4 (h) If there are revenues available in the fund after the Mental
5 Health Services Oversight and Accountability Commission has
6 determined there are prudent reserves and no unmet needs for any
7 of the programs funded pursuant to this section, including all
8 purposes of the Prevention and Early Intervention Program, the
9 commission shall develop a plan for expenditures of these revenues
10 to further the purposes of this act and the Legislature may
11 appropriate these funds for any purpose consistent with the
12 commission's adopted plan that furthers the purposes of this act.
13 (i) For the 2011–12 fiscal year, General Fund revenues will be
14 insufficient to fully fund many existing mental health programs,
15 including Early and Periodic Screening, Diagnosis, and Treatment
16 (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and
17 mental health services provided for special education pupils. In
18 order to adequately fund those programs for the 2011–12 fiscal
19 year and avoid deeper reductions in programs that serve individuals
20 with severe mental illness and the most vulnerable, medically
21 needy citizens of the state, prior to distribution of funds under
22 paragraphs (1) to (6), inclusive, of subdivision (a), effective July
23 1, 2011, moneys shall be allocated from the Mental Health Services
24 Fund to the counties as follows:
25 (1) Commencing July 1, 2011, one hundred eighty-three million
26 six hundred thousand dollars ($183,600,000) of the funds available
27 as of July 1, 2011, in the Mental Health Services Fund, shall be
28 allocated in a manner consistent with subdivision (c) of Section
29 5778 and based on a formula determined by the state in
30 consultation with the County Behavioral Health Directors
31 Association of California to meet the fiscal year 2011–12 General
32 Fund obligation for Medi-Cal Specialty Mental Health Managed
33 Care.
34 (2) Upon completion of the allocation in paragraph (1), the
35 Controller shall distribute to counties ninety-eight million five
36 hundred eighty-six thousand dollars ($98,586,000) from the Mental
37 Health Services Fund for mental health services for special
38 education pupils based on a formula determined by the state in
39 consultation with the County Behavioral Health Directors
40 Association of California.

1 (3) Upon completion of the allocation in paragraph (2), the
2 Controller shall distribute to counties 50 percent of their 2011–12
3 Mental Health Services Act component allocations consistent with
4 Sections 5847 and 5891, not to exceed four hundred eighty-eight
5 million dollars ($488,000,000). This allocation shall commence
6 beginning August 1, 2011.
7 (4) Upon completion of the allocation in paragraph (3), and as
8 revenues are deposited into the Mental Health Services Fund, the
9 Controller shall distribute five hundred seventy-nine million dollars
10 ($579,000,000) from the Mental Health Services Fund to counties
11 to meet the General Fund obligation for EPSDT for the 2011–12
12 fiscal year. These revenues shall be distributed to counties on a
13 quarterly basis and based on a formula determined by the state in
14 consultation with the County Behavioral Health Directors
15 Association of California. These funds shall not be subject to
16 reconciliation or cost settlement.
17 (5) The Controller shall distribute to counties the remaining
18 2011–12 Mental Health Services Act component allocations
19 consistent with Sections 5847 and 5891, beginning no later than
20 April 30, 2012. These remaining allocations shall be made on a
21 monthly basis.
22 (6) The total one-time allocation from the Mental Health
23 Services Fund for EPSDT, Medi-Cal Specialty Mental Health
24 Managed Care, and mental health services provided to special
25 education pupils as referenced shall not exceed eight hundred
26 sixty-two million dollars ($862,000,000). Any revenues deposited
27 in the Mental Health Services Fund in the 2011–12 fiscal year that
28 exceed this obligation shall be distributed to counties for remaining
29 fiscal year 2011–12 Mental Health Services Act component
30 allocations, consistent with Sections 5847 and 5891.
31 (j) Subdivision (i) shall not be subject to repayment.
32 (k) Subdivision (i) shall become inoperative on July 1, 2012.
33 SEC. 3. Section 5892.3 is added to the Welfare and Institutions
34 Code, to read:
35 5892.3. (a) There is hereby established in the State ~~Treasury,~~
36 *Treasury* the Mental Health Services Act Reversion Fund.
37 (b) (1) Other than funds placed in a reserve in accordance with
38 an approved plan, any funds allocated since the 2008–09 fiscal
39 year to a large, medium, small, or very small county that have not
40 been spent for their authorized purpose within three years of being

allocated, and any interest earned on unspent funds, shall revert to the state to be deposited into the Mental Health Services Act Reversion Fund. However, funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Mental Health Services Act Reversion Fund.

(2) (A) For purposes of this subdivision, the following definitions apply:

(i) "Large county" is a county with a population greater than 750,000.

(ii) "Medium county" is a county with a population between 200,000 and 750,000, inclusive.

(iii) "Small county" is a county with a population of 100,000 or greater and less than 200,000.

(iv) "Very small county" is a county with a population less than 100,000.

(B) The populations provided in subparagraph (A) shall be based on annual demographic information released annually by the Department of Finance.

(3) Notwithstanding paragraph (1), a very small county may apply for a waiver, subject to approval by the Mental Health Oversight and Accountability Commission, requesting a delay of the reversion of funds beyond three fiscal years from the time of allocation of funds, but not for more than five fiscal years from the time of allocation of funds.

(c) (1) The state shall distribute funds reverted to the Mental Health Services Act Reversion Fund to counties, or counties acting jointly, to fund prevention and early intervention or ~~innovative programs for youth~~ *innovation programs* that are consistent with mental health funding priorities ~~for youth~~ established by the Legislature and the Mental Health Services Act, including, but not limited to, all of the following:

(A) Providing evidence-based prevention and early intervention ~~services, as described in paragraph (3),~~ *services* to children under five years of age.

(B) Providing evidence-based intervention services and supports for prevention, early detection, and treatment of psychosis, mood disorders, or other mental health ~~issues, as described in paragraph (3),~~ *issues* in educational settings, up to and including higher education.

(C) Providing evidence-based early intervention services and supports for prevention, early detection, and treatment of psychosis, mood disorders, or other mental health ~~issues, as described in paragraph (3),~~ *issues* for youth and transition-age youth involved in the juvenile justice system.

(2) The amount of funds available to counties, or counties acting jointly, for the purposes of this subdivision in any fiscal year is subject to an annual appropriation by the Legislature in the annual Budget Act.

~~(3) Funding shall be directed only to counties, or counties acting jointly, that provide evidence-based intervention services and supports for prevention, early detection, and treatment of psychosis, mood disorders, or other mental health issues for youth, which utilize evidence-based approaches and services to identify and support clinical and functional recovery of young individuals by reducing the severity of first or early episode psychotic symptoms, keeping youth in school, and putting them on a path to better health and wellness. These services and supports may include, but are not limited to, all of the following:~~

~~(A) Focused outreach to at-risk and in-need populations, as applicable.~~

~~(B) Focused programs that build social, emotional, cognitive, or substance refusal skills.~~

~~(C) Recovery-oriented psychotherapy.~~

~~(D) Family psychoeducation and support.~~

~~(E) Supported education and employment.~~

~~(F) Pharmacotherapy and primary care coordination.~~

~~(G) Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.~~

~~(H) Case management.~~

~~(4)~~

(3) Counties, or counties acting jointly, seeking funding from the Mental Health Services Act Reversion Fund ~~for services and supports described in paragraph (3)~~ shall demonstrate to the Mental Health Services Oversight and Accountability Commission that funding will be used to create, or expand existing capacity for, ~~those services and supports.~~ *services and supports that address unmet community needs.* The commission shall submit to the Legislature an annual report of its recommendations for recipients

of funding and the amount of funding for each recipient in a manner that ensures that allocation of funds results in cost-effective and evidence-based services and supports that comprehensively address identified needs ~~of the target population~~ in counties and regions selected for funding. The commission shall also take into account at least the following criteria when recommending recipients of funding and the amount of funding for each recipient:

(A) A description of need, ~~including, at a minimum, a comprehensive description of the services and supports described in paragraph (3) to be established or expanded,~~ *including* community need, the target population to be served, linkage with other public systems of health and mental health care, linkage with ~~schools and~~ community social services, and related assistance as applicable, and a description of the request for funding.

(B) A description of all programmatic components, including outreach and clinical aspects, of local services and ~~supports described in paragraph (3).~~ *supports.*

(C) A description of any contractual relationships with contracting providers, as applicable, including a memorandum of understanding among any project partners.

(D) A description of local funds, including amounts, to contribute toward the services and supports, as required by the commission, implementing guidelines, and regulations.

(E) A project timeline.

(F) The ability of the county, or counties acting jointly, to effectively and efficiently implement or expand services and ~~supports described in paragraph (3).~~ *supports.*

(G) A description of core data collection and a framework for evaluating outcomes, including improved access to services and supports and the cost benefit of the project.

(H) A description of the sustainability of program services and supports in future years.

~~(5)~~

(4) The commission shall determine any minimum or maximum funding recommended to the Legislature for appropriation, shall take into consideration the level of need, the population to be served, and related criteria as described in paragraph ~~(4)~~ *(3)* and in any guidance or regulations, and shall reflect reasonable costs.

~~(6)~~

1 *(5)* Funds appropriated by the Legislature for purposes of this
2 section may be used to supplement, but shall not supplant, existing
3 financial and resource commitments of the county or counties
4 acting jointly.
5 ~~(7)~~
6 *(6)* The Legislature, when making an appropriation from the
7 Mental Health Services Act Reversion Fund, may give specific
8 consideration to very small counties and small counties, as defined
9 in subdivision (b).
10 ~~(8)~~
11 *(7)* Counties that previously have been allocated funds under
12 this subdivision shall be eligible for subsequent funding only if
13 the county or counties acting jointly demonstrate improved
14 outcomes or increased levels of service ~~to the youth populations~~
15 ~~described in this section~~ with the use of the previously allocated
16 funds.
17 ~~(9)~~
18 *(8)* In order to evaluate the success of the use of these funds,
19 the Mental Health Services Oversight and Accountability
20 Commission shall require participating counties to submit outcome
21 data within one year of receiving funding, and the commission
22 shall aggregate and report to the Legislature the outcome data for
23 each participating county or counties acting jointly.
24 ~~(10)~~
25 *(9)* The State Department of Health Care Services shall annually
26 report to the Legislature and the commission the amount of funds
27 that are subject to reversion and the interest earned by counties.
28 ~~(11)~~
29 *(10)* The department shall update necessary regulations,
30 processes, and guidance to allow counties, as appropriate, to revise
31 or correct their annual revenue and expenditure reports. The
32 department shall report any revisions to a county's annual revenue
33 and expenditure report within the annual report described in
34 paragraph ~~(10).~~ *(9).*
35 ~~(12)~~
36 *(11)* A report submitted by the commission or the department
37 pursuant to paragraph ~~(4), (5), (9), (10), or (11)~~ *(3), (4), (8), (9),*
38 *or (10)* shall be in compliance with Section 9795 of the
39 Government Code.

SEC. 4. Section 5892.5 of the Welfare and Institutions Code is amended to read:

5892.5. (a) (1) The California Housing Finance Agency, with the concurrence of the State Department of Health Care Services, shall release unencumbered Mental Health Services Fund moneys dedicated to the Mental Health Services Act housing program upon the written request of the respective county. The county shall use these Mental Health Services Fund moneys released by the agency to provide housing assistance to the target populations who are identified in Section 5600.3.

(2) For purposes of this section, “housing assistance” means each of the following:

(A) Rental assistance or capitalized operating subsidies.

(B) Security deposits, utility deposits, or other move-in cost assistance.

(C) Utility payments.

(D) Moving cost assistance.

(E) Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.

(b) For purposes of administering those funds released to a respective county pursuant to subdivision (a), the county shall comply with all of the requirements described in the Mental Health Services Act, including, but not limited to, Sections 5664, 5847, *and 5899, and* subdivision (b) of Section ~~5892.3, and 5899.~~ *5892.3.*

O

SB 192 (Beall)
Mental Health Services Act Reversion Funds
Fact Sheet

ISSUE

Under the Mental Health Services Act (MHSA), other than a prudent reserve, funds allocated to a county that have not been spent within three years of allocation shall revert to the state Mental Health Services Fund (MHSF) for reallocation to other counties in future years. The purpose of this policy is to incentivize counties to expend their allocations in a timely manner.

However, in recent years, media and other reports have indicated that some counties have not spent all of their funds within the three years allotted to them, but since 2008, these funds have not reverted or been used for unmet mental health needs in the community, as specified by the MHSA. Further, counties have reported that they are unable to accurately document the amount of funds subject to reversion due to issues with the annual reports required by the Department of Health Services (DHCS). Legislation is needed to ensure the reversion funds are captured and allocated towards local mental health programs and services in alignment with the Act to address unmet mental health needs in the community.

BACKGROUND

According to the California Health Care Foundation, nearly 1 in 6 California adults has a mental health need, and approximately 1 in 20 suffers from a serious mental illness that makes it difficult to carry out major life activities. Among California children, 1 in 13 suffers from a mental illness that limits participation in daily activities.

To address this issue, in 2004, the voters passed Proposition 63, or the MHSA, which provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults, and seniors. The Act is funded by a one percent income tax on personal income above $1 million and placed into the MHSF, administered by the DHCS. Up to 5 percent of the funds can be set aside for state administration, and the other 95 percent is dedicated to funding local mental health programs and services overseen by the counties.

DHCS, through a formula, distributes MHSA funds among the counties for community services and supports, prevention and early intervention programs, and innovative programs. The Act requires that funds not spent for their authorized purpose within three years, with the exception of a prudent reserve, are returned to the MHSF. Once the funds revert, DHCS then redistributes the funds among all counties through a formula that dedicates the largest share of MHSA funds to the most populous counties.

THIS BILL

SB 192 creates the Mental Health Reversion Fund (MHRF) to capture any MHSA funds a county has not spent in the specified time allotted, with the exception of a prudent reserve. The bill would:

1. Capture any unspent county MHSA funds after the time duration for which a county must spend down their funds.
2. Counties will maintain the three year requirement to spend down their MHSA funds before they revert, but the bill amends the Act to allow for very small counties to apply for a waiver to now have five years before their funds revert.
3. Establish that funds reverted to the Mental Health Reversion Fund (MHRF) shall be allocated to the counties by the State for prevention and early intervention and/or innovative programs to address unmet mental health needs.
4. Establish that the Legislature would determine the statewide priorities, in alignment with the provisions of Prop 63, which the MHRF may fund.
5. Requires counties to provide outcome data for the funds used and for the Mental Health Services Oversight and Accountability Commission to provide to the Legislature an evaluation of that outcome data.
6. Requires the Department of Health Care Services to report annually to the Legislature and the Commission the amount of funds subject to reversion.
7. Requires the DHCS to update necessary regulations, processes, and guidance to allow counties to revise or correct their annual revenue and expenditure reports.

SUPPORT

The Steinberg Institute

FOR MORE INFORMATION

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SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 192
AUTHOR: Beall
VERSION: March 28, 2017
HEARING DATE: April 5, 2017
CONSULTANT: Reyes Diaz

SUBJECT: Mental Health Services Act Reversion Fund

SUMMARY: Establishes the Mental Health Services Act Reversion Fund into which reverted unspent funds, as specified, will be deposited for allocation, by the Legislature, to specified counties for services and supports targeting youth populations, as specified. Requires annual reporting to the Legislature about the funds, as well as recommendations to the Legislature from specified entities on the allocation of the funds.

Existing law:

1) Establishes the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, which provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

2) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the MHSA, develop strategies to overcome stigma, and advise the Governor or the Legislature on mental health policy.

3) Requires any funds allocated to a county that have not been spent for their authorized purpose within three years to revert to the state to be deposited into the Mental Health Services Fund and available for other counties in future years, as specified.

4) Requires the Department of Health Care Services (DHCS), in consultation with the MHSOAC and the California Mental Health Directors Association, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report to, among other things, identify unexpended funds and interest earned on MHSA funds, and determine reversion amounts, if applicable, from prior fiscal year distributions.

5) Requires the Department of Housing and Community Development, for the purposes of the No Place Like Home Program, which provides MHSA funding to counties to develop permanent supportive housing for a specified population, to organize counties into the following competitive groupings based on population:

   a) Los Angeles County;
   b) Large counties with a population of greater than 750,000;
   c) Medium counties with a population between 200,000 to 750,000; and,
   d) Small counties with a population of less than 200,000.

6) Permits the Legislature to amend the MHSA by a two-thirds vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA.

This bill:

1) Establishes, in the State Treasury, the Mental Health Services Act Reversion Fund (Reversion Fund), and requires specified funds allocated since Fiscal Year (FY) 2008-09 to a "large," "medium," "small," or "very small" county, as defined, that have not been spent for their authorized purpose within three years of being allocated, and any interest earned on unspent funds, to revert to the state to be deposited into the Reversion Fund, as specified.

2) Defines "large" county as having a population greater than 750,000; "medium" county as having a population between 200,000 and 750,000; "small" county as having a population of 100,000 or greater and less than 200,000; and "very small" county as having a population of less than 100,000, and requires that the populations be based on demographic information released annually by the Department of Finance.

3) Allows a very small county to apply for a waiver, subject to approval by the MHSOAC, requesting a delay of the reversion of funds beyond three fiscal years from the time of allocation of funds, but not more than five fiscal years from the time of allocation of funds.

4) Requires distribution of funds reverted to the Reversion Fund to counties, or counties acting jointly, upon appropriation annually by the Legislature, to fund prevention and early intervention or innovative programs for youth that are consistent with mental health funding priorities for youth, as specified, including, but not limited to evidence-based prevention and early intervention services, as specified, and evidence-based intervention services and supports for prevention, early detection, and treatment of psychosis, mood disorders, or other mental health issues, as specified, in educational settings, up to and including higher education, as well as for youth and transition-age youth involved in the juvenile justice system.

5) Requires funding to be directed only to counties, or counties acting jointly, that provide evidence-based intervention services and supports, as specified, for youth to identify and support their clinical and functional recovery. Specifies that services and supports include, but are not limited to, focused outreach to at-risk and in-need populations; focused programs that build social, emotional, cognitive, or substance refusal skills; family psychoeducation and support; and case management.

6) Requires counties, or counties acting jointly, that seek funding from the Reversion Fund to demonstrate to the MHSOAC that funding will be used to create, or expand existing capacity for, specified services and supports. Requires the MHSOAC to submit to the Legislature an annual report of its recommendations for recipients of funding and the amount of funding, as specified. Requires the MHSOAC to take into account specified criteria when recommending recipients, including, but not limited to, a description of need, a description of all programmatic components, a description of local funds to contribute toward services and supports, and a description of the sustainability of program services and supports in future years.

7) Allows funds appropriated by the Legislature for specified purposes to be used to supplement, and prohibits the funds from supplanting, existing financial and resource commitments of a county or counties acting jointly. Allows the Legislature, when making an appropriation from the Reversion Fund, to give specific consideration to very small and small counties.

8) Requires counties that had previously been allocated funds to be eligible for subsequent funding only if the county, or counties acting jointly, demonstrate improved outcomes or increased levels of service, as specified.

9) Requires the MHSOAC to require participating counties to submit outcome data within one year of receiving funding, and to aggregate and report to the Legislature the outcome data, as specified.

10) Requires DHCS to annually report to the Legislature and the MHSOAC the amount of funds that are subject to reversion and the interest earned by counties. Requires DHCS to update necessary regulations, processes, and guidance to allow counties to revise or correct their Annual Revenue and Expenditure Reports, as specified.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, the California Health Care Foundation states that nearly one in six California adults has a mental health need, and approximately one in 20 suffers from a serious mental illness that makes it difficult to carry out major life activities. Among California children, one in 13 suffers from a mental illness that limits participation in daily activities. To address this issue, in 2004, the voters passed Proposition 63, which provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults, and seniors. In recent years, media and other reports have indicated that some counties have not spent all of their funds within the three years allotted to them, but not all of those funds have reverted as specified by the MHSA. In addition, county implementation of the MHSA gives local control for the use of the funds, without regard to potential statewide needs or priorities. Legislation is needed to ensure the reversion funds are captured and allocated towards local mental health programs and services in alignment with the MHSA and priorities set by the Legislature.

2) *Background.* The MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to counties related to each component of the MHSA, including, among other things, community services and support content to provide integrated mental health and other support services to those whose needs are not currently met through other funding sources; prevention and early intervention content to provide services to avert mental health crises; and innovative program content to improve access to mental health services.

   In the three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties also must submit their plans for approval to the MHSOAC before they can spend certain categories of funding. Under current law, counties have three years to use MHSA funds allocated to them. After the three years, any unspent funds are required to be reverted back to the state for allocation to other counties in future years.

3) *Reversion of funds.* According to information provided by the author, media and other reports over the years have indicated that some counties have not spent all of their MHSA funds within the required three-year timeframe, and not all of those funds have reverted as

specified by current law. Further, when the funds do revert, they are redistributed to the counties through a formula that benefits the largest, most populous counties without a specified purpose for the use of the funds beyond the requirement that the funds be used for MHSA-eligible services and programs. According to a document titled "MHSA Funds Reverted" on DHCS's Web site, the last time funds were reverted was in FY 2007-08. Another page on DHCS's Web site, "Annual Revenue and Expenditure Reports by County," shows that while expenditure reports are required to be submitted to DHCS not all counties have consistently reported, and no reports for FY 2014-15 have yet been made available on DHCS's Web site. According to a document by the MHSOAC of statewide unspent funds gathered from available Annual Revenue and Expenditure Reports, for FY 2014-15, there is an estimated $32.1 million of unspent revenues from FY 2010-11 and prior fiscal years, and an available estimated $27.6 million of unspent interest earned on the unspent funds, which have not yet been reverted.

Committee staff also contacted DHCS in mid-March to ask about when they last reverted MHSA funds and whether or not DHCS has a new policy related to MHSA reversion. As of March 30, 2017, DHCS has not provided an official response to committee staff.

4) *Little Hoover Commission report.* In January 2015, the Little Hoover Commission (LHC) issued a report, "Promises Still to Keep: A Decade of the Mental Health Services Act," that found that funding provided by the MHSA—approximately more than $1 billion annually and representing about 25% of California's overall mental health spending—continues to evade effective evaluation due to antiquated state technology and overlapping and sometimes unaccountable bureaucracies. The LHC report states that the Legislature appropriately empowered the MHSOAC by making it independent of the state Department of Mental Health (which administered the MHSA before transfer to DHCS) but that it still lacks teeth and shares oversight responsibilities for the MHSA with DHCS. The LHC report recommends, among other things, that the Legislature expand MHSOAC's authority, specifically that the MHSOAC be empowered to impose sanctions if counties misspend funds from the act or fail to timely file reports with the state.

5) *Related legislation.* SB 688 (Moorlach) would require MHSA funds allocated for administration, as specified, to include amounts sufficient for DHCS to establish a contract and an interagency data sharing agreement with the University of California to ensure adequate research and evaluation, as specified. *SB 688 is pending in the Senate Health Committee.*

   AB 974 (Quirk-Silva) would require counties to report spending on mental health services for veterans from MHSA funds. *AB 974 is pending in the Assembly Health Committee.*

   AB 727 (Nazarian) clarifies that counties may spend MHSA funds on housing assistance, as defined, for people in the target population. *AB 727 is set for hearing in the Assembly Health Committee on April 4, 2017.*

   AB 488 (Kiley) establishes the Mental Health Services Fund Transparency and Accountability Office within the California Health and Human Services Agency, as specified, and transfers various DHCS functions to the office. *AB 488 is pending in the Assembly Health Committee.*

6) *Prior legislation.* AB 1628 (Committee on Budget, Chapter 322, Statutes of 2016) among other things, establishes and continuously appropriates the Supportive Housing Program Subaccount in the Mental Health Services Fund for counties to develop permanent supportive housing, as specified.

   SB 82 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2013) made a one-time appropriation of $500,000 from the General Fund to the California Health Facilities Financing Authority to implement grant programs to support the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services for individuals with mental health disorders, including the services contained in this bill.

   SB 585 (Steinberg, Chapter 288, Statutes of 2013) allows counties, when included in their plans, to use Mental Health Services Fund monies for Assisted Outpatient Treatment, known as "Laura's Law," if a county elects to participate in and implement Laura's Law.

7) *Support.* The Steinberg Institute states that this bill provides the opportunity to expand evidence-based early psychosis and mood disorder detection and intervention services and supports to transition-aged youth and young adults. The Steinberg Institutes states that while data as to the amount of any unspent MHSA funding is inconsistent, it supports the targeted redistribution of any reverted funding toward early intervention and innovations programs, and that by focusing on prevention amount youth, this funding will increase outcome-based services and facilitate wellness.

8) *Opposition.* The Los Angeles County Board of Supervisors states that their county Department of Mental Health reports that a reversion requirement should remain the same for all counties regardless of size, and that counties should not be restricted based on size to a maximum grant amount but rather all counties should have open access to reverted funds to the full extend funds are available. The California Behavioral Health Directors Association of California (CBHDAC) states that this bill's proposal to disburse grants based on legislative priorities is not aligned with voters' intent of the MHSA, as it requires local priorities articulated by consumers, families, service providers, and other stakeholders to guide the investments each local community makes with MHSA funds. CBHDAC further states that the currently required stakeholder driven community planning process means that MHSA programming is tailored to local needs, and that establishing a program based on legislative priorities moves decision making further away from those knowledgeable about local needs and service gaps.

9) *Policy comments.*

   a) *DHCS's role in reverting funds.* Current law requires the reversion of unspent MHSA funds from counties every three years to be reallocated to other counties with unmet needs. However, these reversion requirements have not been enforced by DHCS since 2008. Committee staff has inquired in years past and most recently in March 2017 about DHCS reversion policy and why reversion of funds has not been enforced. While DHCS has stated at MHSOAC public meetings that it is working on an updated policy, no official statement from the department on this question has been provided.

b) *Reversion fund priorities.* This bill narrows the scope of those served by the MHSA from the Reversion Fund by specifying that these funds be used for programs that prioritize youth mental health services, including in educational settings and transition-age youth involved in the juvenile justice system. Currently, a wide array of services and supports benefit from MHSA funds, and in theory reversion funds, including adults and seniors, housing, and workforce development. While the services targeted under this bill are consistent with the MHSA, the Committee may wish to consider if California should narrow the scope of people being served through these funds rather than supporting all services that are consistent with the MHSA.

SUPPORT AND OPPOSITION:
Support: Steinberg Institute

Oppose: Los Angeles County Board of Supervisors
County Behavioral Health Directors Association of California

-- END --

AGENDA ITEM 3

Action

April 27, 2017 Commission Meeting

Assembly Bill 254: Local Educational Agency Pilot for Overall Needs

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Summary: Assembly Member Tony Thurmond will provide background and overview on Assembly Bill 254. This bill, as currently drafted, requires the Department of Health Care Services (DHCS), in cooperation with the California Department of Education (CDE), to establish the Local Educational Agency Pilot for Overall Needs (Pilot Program) for the purpose of improving the mental health outcomes of students through a whole person care approach that is accomplished by providing funding to an eligible participant for the provision of direct health services. The bill would require the DHCS to encourage eligible participants to participate in the program, to provide technical assistance to eligible participants, and to develop a request for proposals process to determine funding allocation.

Presenter: Assembly Member Tony Thurmond

Enclosures: Assembly Bill 254; AB 254 Fact Sheet; Assembly Committee on Health Analysis.

Handout: None

Recommended Action: Staff requests direction from the Commission regarding Assembly Bill 254.

AMENDED IN ASSEMBLY APRIL 17, 2017

AMENDED IN ASSEMBLY MARCH 23, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 254

Introduced by Assembly Member Thurmond

January 31, 2017

An act to add Article 2.986 (commencing with Section 14094.25) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to health care services.

LEGISLATIVE COUNSEL'S DIGEST

AB 254, as amended, Thurmond. Local Educational Agency Pilot for Overall Needs.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law provides that specified services provided by local educational agencies (LEAs) are covered Medi-Cal benefits, including, but not limited to, mental health evaluations, mental health education, and mental health and counseling services. Existing law provides that an LEA may be reimbursed for the provision of those benefits on a fee-for-service basis through the Medi-Cal billing option for LEAs.

This bill would require the department, upon appropriation of funds, to establish the Local Educational Agency Pilot for Overall Needs (program) for the purpose of improving the mental health outcomes of students through a whole person care approach that is accomplished by

providing funding to an eligible participant for the provision of direct health services, as defined. The bill would require the department to encourage eligible participants to participate in the program, to provide technical assistance to eligible participants, and to develop a request for proposals process to determine funding allocation. The bill would require an LEA receiving funding through the program to use funds received to increase direct health services provided to all registered students, with a concerted effort toward providing services to students enrolled in the Medi-Cal program. The bill would authorize an LEA to provide direct health services through direct employment of health care providers, or by contracting, as specified, with health care providers or school health centers, as defined. The bill would require a school health center that contracts with an LEA under the program to work in partnership with the school nurse to deliver direct health services, to serve all registered students, and to seek reimbursement for services provided from private health insurers or health care service plans, if applicable. The bill would provide for implementation of the program upon appropriation of funds for the program and to the extent that any necessary federal approvals have been obtained. The bill would require the program to operate for 4 years from the date of that appropriation. The bill would require the department, upon termination of the program and depletion of appropriated funds, to report to the Legislature, as specified, on the outcomes of the program and the need for funding school-based health services and their connection to early mental health outcomes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Article 2.986 (commencing with Section
2 14094.25) is added to Chapter 7 of Part 3 of Division 9 of the
3 Welfare and Institutions Code, to read:
4
5 Article 2.986. Local Educational Agency Pilot for Overall Needs
6
7 14094.25. For the purposes of this chapter, the following
8 definitions shall apply:
9 (a) “Department” means the State Department of Health Care
10 Services.

(b) “Eligible participant” means either of the following:

(1) A local educational agency (LEA) that does not participate in the Medi-Cal billing option for LEAs authorized pursuant to Section 14132.06.

(2) An LEA that participates in the Medi-Cal billing option for LEAs authorized pursuant to Section 14132.06, but which receives low reimbursement relative to the number of students enrolled in the Medi-Cal program who would be eligible to receive covered services.

(c) “Direct health services” means those services that the department has identified as reimbursable services under the Medi-Cal billing option for LEAs pursuant to Section ~~14132.06.~~ *14132.06 and physical and mental health care services that are not covered under the Medi-Cal billing option for LEAs, including, but not limited to, any or all of the following:*

(1) Management of chronic medical conditions.

(2) Basic laboratory tests.

(3) Reproductive health services.

(4) Nutrition services.

(5) Mental health and alcohol and substance abuse service assessments, crisis intervention, counseling, treatment, and referral to a continuum of services, including, but not limited to, emergency psychiatric care, evidence-based mental health or alcohol and substance abuse treatment services, community support programs, inpatient care, and outpatient programs.

(6) Oral health services, including, but not limited to, preventive services, basic restorative services, and referral to specialty services.

(d) “Program” means the Local Educational Agency Pilot for Overall Needs established pursuant to this article.

(e) “School health center” means a center or program, located at or near an LEA, that provides age-appropriate health care services at the program site or through referrals.

14094.27. (a) The department, in cooperation with the State Department of Education, shall establish the Local Educational Agency Pilot for Overall Needs for the purpose of ~~improving the mental health outcomes of students through a whole person care approach that is accomplished by providing funding to an eligible participant for the provision of direct health services.~~ *increasing*

1 *comprehensive and integrated physical and mental health services*
2 *as part of a whole person care approach.*
3 (b) In implementing the program, the department shall do all
4 of the following:
5 (1) Encourage the participation in the program of eligible
6 participants that are not yet participating in the program.
7 (2) Provide technical assistance to LEAs that seek to participate
8 in the program or that are eligible participants. For the purposes
9 of this article, technical assistance includes, but is not limited to,
10 identifying public and private funding sources that will assist the
11 LEA in enrolling students in the Medi-Cal program.
12 (3) Develop a request for proposals process that collects
13 applicant information and determines which proposals shall receive
14 funding.
15 14094.29. (a) An LEA that participates in the program shall
16 do all of the following:
17 (1) Use funds received through the program to increase direct
18 health services provided to all registered students, with a concerted
19 effort toward providing services to students enrolled in the
20 Medi-Cal program. Funds received through the program shall be
21 used to fund new *on-site direct health* services not already provided
22 by the ~~LEA, including, but not limited to, mental health services.~~
23 *LEA.*
24 (2) Make a concerted effort toward enrolling students eligible
25 for the Medi-Cal program into the Medi-Cal program.
26 *(3) Strive to provide integrated physical and mental health*
27 *services that are individualized and supportive of students and,*
28 *where appropriate, their families, to ensure that health, social, or*
29 *behavioral challenges are addressed.*
30 *(4) Create a sustainability plan that establishes how the LEA*
31 *will seek to maximize the use of public funds, including, but not*
32 *limited to, participation in federal reimbursement programs.*
33 (b) An LEA that participates in the program shall participate in
34 the Medi-Cal billing option for LEAs by the time the LEA begins
35 participation in the program.
36 (c) A reimbursement received through the program for direct
37 health services provided by the LEA shall be used in accordance
38 with applicable federal laws, regulations, or guidelines.
39 (d) An LEA participating in the program may provide direct
40 health services through direct employment of health care providers,

such as school nurses, or by contracting with other health care providers or school health centers for the purpose of supplementing services. The Legislature does not intend for a school health center to serve as a substitute for a school nurse directly employed by an LEA.

14094.31. An LEA that contracts with a health care provider or school health center pursuant to subdivision (d) of Section 14094.29 shall do both of the following:

(a) Create and maintain a mechanism, described in writing, to coordinate services provided to individual students among school staff and school health center staff while maintaining the confidentiality and privacy of health information consistent with applicable state and federal law.

(b) Create and maintain a contract or memorandum of understanding between the LEA, the health care provider or school health center, and any other provider agencies that describes the relationship between the LEA and the school health center, if applicable.

14094.33. (a) A school health center that contracts with an LEA pursuant to subdivision (d) of Section 14094.29 shall be or shall be eligible to become an enrolled Medi-Cal provider at the time of contracting and shall do all of the following:

(1) Work in partnership with the school nurse, if one is employed by the LEA, to provide direct health services that are either not provided by the LEA or that are provided by the LEA but require supplementation in order to improve services delivered to students under the program.

(2) Serve all registered students enrolled in school without regard to ability to pay, with a concerted effort toward providing services to students enrolled in the Medi-Cal program.

(3) Seek reimbursement from and have procedures in place for billing public and private health insurers or health care service plans for covered services provided to students by the school health center.

(b) For the purposes of the program, a school health center may provide direct health services and may provide referrals for services not offered at the school health center site.

(c) A school health center may serve two or more nonadjacent schools or LEAs.

1 14094.35. (a) This article shall be implemented only upon
2 appropriation of funds for the program and to the extent that any
3 necessary federal approvals have been obtained.
4 (b) The program shall operate for four years from the date of
5 the appropriation described in subdivision (a), notwithstanding
6 fiscal years.
7 14094.37. (a) Upon the depletion of funds appropriated for
8 the program and the termination of the program, the department
9 shall submit a report to the Assembly Committee on Appropriations
10 and the Senate Committee on Appropriations that shall include,
11 but not be limited to, all of the following information:
12 (1) An evaluation of the need for funding school-based health
13 services and their connection to early mental health outcomes.
14 (2) The impact of the program on student well-being, academic
15 achievement, school engagement, attendance, and other outcome
16 and indicator measures collected by LEAs participating in the
17 program.
18 (b) Information reported pursuant to subdivision (a) shall be
19 reported in the aggregate and shall not be reported in a manner
20 that would compromise the privacy of any individual student.

O

Assemblymember Tony Thurmond, 15th Assembly District

AB 254–Comprehensive Healthcare in Schools

IN BRIEF

Establish a pilot program that would maximize participation and federal reimbursement under the LEA Billing Program while increasing the comprehensive healthcare services provided in schools.

BACKGROUND

The Local Education Agency (LEA) Billing Program provides up to a 50% federal reimbursement for a specified direct health services provided to Medi-Cal-enrolled students. Reimbursement is limited to services that are already provided by a school district and cannot go to create a new service, nor replace funding levels for an existing program. Examples of reinvestments can include health care services (e.g. immunizations) and mental health services (e.g. primary prevention and crisis intervention, assessments, or training for teachers to recognize mental health problems).

On September 15, 2015, as allowed by the Federal government, California has joined other states in reversing the free care rule. The removal of this rule now permits reimbursement for Medic-Cal-covered services provided to Medi-Cal enrollees, regardless of whether the service is also provided at no cost to other non-Medi-Cal populations. The reversal frees up schools to seek reimbursement for services to all Medi-Cal students; enhance and expand the role of school districts in the broader health delivery system. In addition, the Department of Health Care Services is in on-going conversations with the Centers for Medicare & Medicaid Services to expand the reimbursable services, providers who can be reimbursed, and a change in the billing methodology that could reduce staff time required.

These potential changes to the LEA Billing Option program present an opportunity for the State of California to promote school-based health care services while attaining a return-on-investment from the federal government. In targeting school districts with students who could most benefit from this pilot program, this bill would improve educational outcomes through more wholesome school-based physical and mental healthcare services.

In recent years, there has been a concerted effort to move towards a collaborative model of care that is sensitive to the overall needs that encompass care—often called the Whole Person Care model. This model extends specifically to the unique needs of vulnerable populations facing significant barriers to access—specifically children and youth in Medi-Cal. These populations are more likely to experience a multitude of physical and behavioral health issues stemming from or amplified by psychosocial challenges such as food insecurity, abuse, or substance misuse in their household. These issues are particularly consequential to the children who exist within these vulnerable populations.

These children face challenges to access of care given their location or that they simply cannot make appointments. In such cases, schools provide the best setting to provide such wholesome care. In recognition of the critical role schools play in addressing the social and emotional needs of students, research indicates that providing physical and mental health services in schools can improve both academic and treatment outcomes. Given this, school-based, school-linked, and community health providers must ensure access to health and mental health services.

SOLUTION

Establish a four-year pilot program under the Department of Health Care Services targeting LEAs who: 1) do not participate in the LEA Billing Option Program, but have a high population of Medi-Cal eligible students 2) participate in the LEA Billing Option Program, but who receive low reimbursement in relation to their Medi-Cal eligible student population. Funds would be used to increase direct health services for their students, not already provided—contingent on their participation in the LEA Billing Option program. LEAs can provide services through direct employment of health care practitioners, such as school nurses, or by contracting with other health care practitioners or School Health Centers to establish or expand physical and menal health services.

SUPPORT

California State PTA
California Alliance of Child and Family Services
California School Nurses Association

FOR MORE INFORMATION

Rodolfo E. Rivera Aquino, Office of Asm. Tony Thurmond
916 319 2015 | Rodolfo.RiveraAquino@asm.ca.gov

Date of Hearing: April 18, 2017

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 254 (Thurmond) – As Amended April 17, 2017

SUBJECT: Local Educational Agency Pilot for Overall Needs.

SUMMARY: Requires the Department of Health Care Services (DHCS), in cooperation with the California Department of Education (CDE), to establish the Local Educational Agency Pilot for Overall Needs (Pilot Program) for the purpose of improving the mental health outcomes of students through a whole person care approach, as specified. Specifically, **this bill**:

1) For purposes of the bill, defines eligible participants as a local education agency (LEA) that does not participate in the LEA Medi-Cal Billing Program (LEA Billing Program) or a LEA that participates in the LEA Billing Program, but receives low reimbursement relative to the number of students enrolled in the Medi-Cal program who would be eligible to receive covered services.

2) Defines direct health services as those services that DHCS has identified as reimbursable services under the LEA Billing Program which may include any or all of the following:

   a) Management of chronic medical conditions;

   b) Basic laboratory tests;

   c) Reproductive health services;

   d) Nutrition services;

   e) Mental health and alcohol and substance abuse service assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, evidence-based mental health or alcohol and substance abuse treatment services, community support programs, inpatient care, and outpatient programs; and,

   f) Oral health services that may include preventive services, basic restorative services, and referral to specialty services.

3) Defines school health center as a center or program, located at or near a LEA, that provides age-appropriate health care services at the program site or through referrals.

4) Requires DHCS to do all of the following:

   a) Encourage the participation in the Pilot Program of eligible participants that are not yet participating in the LEA Billing Program;

   b) Provide technical assistance to LEAs that seek to participate in the Pilot Program or that are eligible participants, including but not limited to, identifying public and private funding sources that will assist the LEA in enrolling students in the Medi-Cal program; and,

c) Develop a request for proposals process that collects applicant information and determines which proposals shall receive funding.

5) Requires a participating LEA to do all of the following:

   a) Use funds received through the Pilot Program to increase direct health services provided to all registered students, with a concerted effort toward providing services to students enrolled in the Medi-Cal program and require LEA to use funds received through the program to fund new on-site direct health services not already provided by the LEA, including, but not limited to, mental health services;

   b) Strive to provide integrated physical and mental health services that are individualized and in support of students, and where appropriate their families, to ensure that health, social, or behavioral challenges are addressed;

   c) Make a concerted effort toward enrolling students eligible for the Medi-Cal program into the Medi-Cal program;

   d) Participate in the LEA Billing Program by the time the LEA begins participation in the program;

   e) Utilize reimbursements received through the program for direct health services provided by the LEA in accordance with applicable federal laws, regulations, or guidelines; and,

   f) Show a sustainability plan that establishes how the LEA seeks to maximize the use of public, including but not limited to participation in federal reimbursement programs.

6) Permits a LEA participating in the program to provide direct health services through direct employment of health care providers, such as school nurses, or by contracting with other health care providers or school health centers for the purpose of supplementing services. The Legislature does not intend for a school health center to serve as a substitute for a school nurse directly employed by a LEA.

7) Requires a LEA that contracts with a health care provider or school health center to create and maintain a mechanism to coordinate services provided to individual students while maintaining the confidentiality and privacy of health information, and to create and maintain a contract or memorandum of understanding between the LEA, the health care provider or school health center, and any other provider agencies that describes the relationship between the LEA and the school health center, as specified.

8) Requires a school health center that contracts with a LEA to become an enrolled Medi-Cal provider at the time of contracting and to do all of the following:

   a) Work in partnership with the school nurse, if one is employed by the LEA, to provide direct health services that are either not provided by the LEA or that are provided by the LEA but require supplementation in order to improve services delivered to students under the program;

b) Serve all registered students enrolled in school without regard to ability to pay, with a concerted effort toward providing services to students enrolled in the Medi-Cal program; and,

c) Seek reimbursement from and have procedures in place for billing public and private health insurers or health care service plans for covered services provided to students by the school health center.

9) Permits a school health center to provide direct health services and allows referrals for services not offered at the school health center site.

10) Permits a school health center to serve two or more nonadjacent schools or LEAs.

11) Makes implementation of the Pilot Program contingent on an appropriation of funds for the program and requires any necessary federal approvals to be been obtained. Establishes a sunset of the Pilot Program four years from the date of the appropriation.

12) Requires DHCS, upon the depletion of funds appropriated for the program and the termination of the program, to submit a report to the Assembly Committee on Appropriations and the Senate Committee on Appropriations that includes, but is not limited to, all of the following information:

a) An evaluation of the need for funding school-based health services and their connection to early mental health outcomes; and,

b) The impact of the program on student well-being, academic achievement, school engagement, attendance, and other outcome and indicator measures collected by LEAs participating in the program.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS under which qualified low-income individuals receive health care services.

2) Requires that specified services provided by a LEA are covered Medi-Cal benefits, to the extent federal financial participation (FFP) is available, are subject to utilization controls and standards adopted by DHCS, and are consistent with Medi-Cal requirements for physician prescription, order, and supervision.

3) Requires DHCS to amend the Medicaid state plan with respect to the LEA Billing Program for services provided by LEAs, to ensure that schools be reimbursed for all eligible services that they provide that are not precluded by federal requirements.

4) Authorizes DHCS to contract with LGAs or local education consortiums (LECs) to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program through the Medi-Cal Administrative Activities (MAA) program.

5) Defines the scope of covered services that a LEA may provide, including targeted case management services for children with an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP).

6) Permits DHCS to contract with each participating LGA or each LEC to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program.

7) Requires DHCS to examine methodologies for increasing school participation in the Medi-Cal billing option for LEAs so that schools can meet the health care needs of their students and requires DHCS to simplify claiming processes for LEA billing.

8) Requires DHCS to regularly consult with CDE, representatives of urban, rural, large and small school districts, county offices of education, the LECs, and LEAs to assist in formulating the state plan amendment.

9) Requires each LEA that elects to participate in the MAA program to submit claims through its LEC or LGA, but not both.

10) Defines a LEA for purposes of the MAA program as the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus that participates in the Administrative Claiming process as a subcontractor to the LEC in its service region.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, school settings present an important resource for the provision of both physical and mental health. They are the center of communities and a place parents know and trust. Given the inextricable relationship between education and health, if the State of California seeks to lead in education we must also focus on the provision of healthcare. This bill would provide school districts the funding needed to expand services, both physical and mental health. School-based health improves student academic achievement, increases attendance, reduces dropout rates, improves behavior, and promotes parent engagement.

1) **BACKGROUND.**

   a) **LEA Billing Program.** The LEA Billing Program was established in 1993 in conjunction with CDE and has provided Medicaid funds to LEAs for health-related services provided to students who have IEPs or IFSPs. The LEA Billing Program provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment. A LEA provider employs or contracts with qualified medical practitioners to render certain health services Reimbursement is based upon a "fee-for-service" model. School expenditures for services rendered are reimbursed at 50% of cost. Eligible services include the following:

      i) Health and Mental Health Evaluation and Education (Assessments);
      ii) Physical Therapy;

- **iii)** Occupational Therapy;
- **iv)** Speech Therapy;
- **v)** Audiology Services;
- **vi)** Psychology and Counseling;
- **vii)** Nursing Services and Trained Health Care Aide Services;
- **viii)** Physician Services;
- **ix)** Medical Transportation and Mileage; and,
- **x)** Targeted Case Management Services.

b) Recent change in federal policy. Prior to 2014, under long-standing policy known as the "free care rule," LEAs could not receive payment for services which they made available without charge to Medi-Cal eligible students or to the community at large unless all students were billed for the service. For example, if all children in a school received hearing evaluations, Medi-Cal could not be billed for the hearing evaluations provided to Medi-Cal recipients unless all students, regardless of insurance status, were billed for the services as well. This meant that before being able to bill, schools had to bill a variety of private insurers as well as Medi-Cal. This was an administrative burden that many LEAs found prohibitive.

In December, 2014, the Centers for Medicare and Medicaid Services issued new guidance which will allow LEAs to serve all Medi-Cal-eligible students, whether or not they have an IEP or an IFSP. While California receives the largest total share of federal funds, the amount the state receives per eligible student is low relative to other states. In 2009-10, California served 240,000 of its 3.3 million eligible students, resulting in an average of $159 per eligible student. The average among the 32 states surveyed was $544 per eligible student. Nebraska (with 103,000 eligible students) received $796 per eligible student, Vermont received $694 per eligible student, and Rhode Island received $635 per eligible student (all figures include Medicaid administrative funds).

The December 2014 guidance reversed the above administrative requirement, allowing Medicaid reimbursement for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, funding is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met.

c) State Auditor Report. An August 2015 report by the California State Auditor (CSA) titled "California Department of Health Care Services: It Should Improve Its Administration and Oversight of School-Based Medi-Cal Programs," (report) indicated several areas for improvement in the administration of the LEA Billing Program and MAA Programs. The report indicates that DHCS has displayed certain weaknesses in its administration of school-based Medi-Cal programs, which consists of the School-Based MAA program and the LEA Billing Program. For instance, DHCS has not maximized the participation of claiming units in the MAA Program, and CSA estimates that 275, or 27%, of the 1,004 LEAs did not participate in the administrative activities program during fiscal year 2011-12, resulting in a loss to the State of an estimated $10.2 million in federal reimbursements. In addition, DHCS delegated responsibility for maximizing claiming unit participation to LECs and LGAs but did not adequately oversee their efforts. CSA also notes that DHCS did not maximize federal reimbursement for the

MAA program by failing to authorize claiming units to claim reimbursement for translation activities at a 75% rate as federal law currently allows rather than the 50% rate it previously allowed. Because the claiming units used the lower rate, CSA estimates that they failed to claim $4.6 million in federal funding from February 2009, through June 2015.

2) **SUPPORT.** The California School Nurses Organization states in support that school nurses spend over 30% of their time addressing the emotional and mental health issues of their students. Yet, many of these problems continue to impact students' functioning in school. This bill will address some of the barriers that prevent schools from participating in the LEA billing program, increase the reimbursement to schools for the services they provide, and hopefully supplement and expand the existing staff required to provide critical health and mental health services to vulnerable children.

   The California State PTA states in support that in recent years, there has been a concerted effort to move towards a collaborative model of care that is sensitive to the overall needs that encompass care, known as the Whole Person Care model. This model addresses the unique needs of vulnerable populations facing significant barriers to access, specifically children and youth in Medi-Cal. These populations are more likely to experience a multitude of physical and behavioral health issues stemming from or amplified by psychosocial challenges such as food insecurity, abuse, or substance misuse in their household. This bill would allow LEAs to increase direct health services for their students through direct employment of health care practitioners or by contracting with other health care practitioners to establish or expand physical and mental health services.

3) **OPPOSITION.** The California Right to Life Committee (CRLC) states in opposition to the bill that the stated purpose for funding and encouraging LEAs to enroll more students in Medi-Cal programs through school based centers is for the purpose of improving the mental health outcomes of students through a Whole Person Care approach. CRLC questions what this approach includes and notes that no definition is provided in the bill.

4) **RELATED LEGISLATION.**

   a) AB 834 (O'Donnell) requires CDE to establish the Office of School-Based Health Programs (OSBHP) by July 1, 2018, for the purpose of administering current health-related programs under the purview of CDE, advising on issues related to the delivery of school-based Medi-Cal services in the state, developing recommendations for an interagency agreement or memorandum of understanding between DHCS and CDE; and, assisting DHCS in formulating the Medi-Cal SPAs necessary to establish a OSBHP and related services. AB 834 is pending in the Assembly Health Committee.

   b) AB 882 (Arambula) would establish the School Nursing and Pupil Health Care Services Task Force consisting of 18 members, appointed as specified, to identify model school health care services programs and practices that directly serve pupils that can be used by county offices of education and school districts to provide support and technical assistance to schools within each jurisdiction in order to improve the safety and quality of health care services to pupils. AB 882 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

   a) SB 123 (Liu) of 2015 would have required the Legislative Analyst's Office, in consultation with CDE and DHCS, to make recommendations relative to the administration and oversight of the MAA program. SB 123 was vetoed by the Governor, who stated:

      This bill establishes a work group jointly administered by the Departments of Health Care Services and Education to recommend changes to school-based Medi-Cal programs.

      There is an advisory committee within the Department of Health Care Services whose very purpose is to continuously review and recommend improvements to these programs. Collaboration among the health and education departments and local education groups is very important, but the existing advisory committee is working well and certainly up to the task. Codification in this case is not needed.

   b) SB 276 (Wolk), Chapter 653, Statutes of 2015, among other provisions, requires the DHCS to seek FFP for covered services that are provided by a LEA to a Medi-Cal eligible child regardless of whether the child has an IEP or an IFSP, or whether those same services are provided at no charge to the child or to the community at large.

   c) AB 1955 (Pan) of 2014, would have required DHCS and CDE to cooperate and coordinate efforts in order to maximize receipt of federal financial participation under the MAA process, and required DHCS, through an interagency agreement with the CDE, to provide technical advice and consultation to local educational agencies participating in a demonstration project established by the bill, in order to meet requirements to certify and bill valid claims for allowable activities under MAA. AB 1955 was held in the Assembly Appropriations Committee.

6) **DOUBLE REFERRAL.** This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Education Committee.

7) **POLICY COMMENT.** The eligibility requirements for participation in the Pilot Program established by this bill include 1) a LEA that does not participate in the LEA Medi-Cal Billing Program or 2) a LEA that participates in the LEA Billing Program, but receives low reimbursement relative to the number of students enrolled in the Medi-Cal program that would be eligible to receive covered services. It is unclear how the determination of "low reimbursement" would be made. The author may wish to consider clarifying how eligibility for LEAs with low reimbursement would be made.

8) **SUGGESTED AMENDMENTS.**

   a) **FFP.** This bill creates an expansion of services in the LEA Billing Program without federal participation/approval. Currently, the following health services are not considered reimbursable services, and would therefore not be eligible for FFP:

      i) Management of chronic medical conditions;
      ii) Basic laboratory tests;

- **iii)** Reproductive health services;
- **iv)** Nutrition services;
- **v)** Mental health and alcohol and substance abuse service assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, evidence-based mental health or alcohol and substance abuse treatment services, community support programs, inpatient care, and outpatient programs; and,
- **vi)** Oral health services that may include preventive services, basic restorative services, and referral to specialty services.

The Committee may wish to specify that necessary Medicaid state plan amendments be required before implementation of the Pilot Program.

b) **Report.** This bill requires a report on the Pilot Program to be submitted only to the Appropriation Committees of the Legislature. The Committee may wish to require the reports to be submitted to the appropriate policy committees.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Child and Adolescent Psychiatry
California Alliance of Child and Family Services
California Immigrant Policy Center
California State Parent Teacher Association
California School Nurses Organization

Opposition

California Right to Life Committee.

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097

AGENDA ITEM 4

Action

April 27, 2017 Commission Meeting

Assembly Bill 1315: Mental Health: Early Psychosis Detection and Intervention

Summary: Maggie Merritt, Executive Director from the Steinberg Institute will provide background and overview on Assembly Bill 1315. This bill, as currently drafted, would establish an advisory committee to the Mental Health Services Oversight and Accountability Commission for purposes of creating an early psychosis detection and intervention competitive selection process to, among other things, expand the provision of high-quality, evidence-based early psychosis detection and intervention services in California by providing funding to the counties for this purpose. The bill would require a county that receives an award of funds for the purposes of these provisions to contribute local funds, as specified. This bill would prescribe the membership of the advisory committee, including the chair of the commission or his or her designee.

Presenter: Assembly Member Kevin Mullin

Enclosures: Assembly Bill 1315; AB 1315 Fact Sheet.

Handout: None

Recommended Action: Staff requests direction from the Commission regarding Assembly Bill 1315.

AMENDED IN ASSEMBLY MARCH 30, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1315

Introduced by Assembly Member Mullin

February 17, 2017

An act *to add Part 3.4 (commencing with Section 5835) to Division 5 of the Welfare and Institutions Code,* relating to mental ~~health.~~ *health, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1315, as amended, Mullin. Mental ~~health.~~ *health: early psychosis detection and intervention.*

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission to oversee various mental health programs funded by the act. Proposition 63 requires the State Department of Health Care Services, in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling.

This bill would establish an advisory committee to the commission for purposes of creating an early psychosis detection and intervention competitive selection process to, among other things, expand the provision of high-quality, evidence-based early psychosis detection and intervention services in this state by providing funding to the counties for this purpose. The bill would require a county that receives an award of funds for the purposes of these provisions to contribute local funds, as specified.

This bill would prescribe the membership of the advisory committee, including the chair of the commission or his or her designee. The committee would, among other duties, provide advice and guidance on approaches to early psychosis detection and intervention programs.

This bill also would establish the Early Psychosis Detection and Intervention Fund within the State Treasury and would provide that moneys in the fund are continuously appropriated to, and under the administrative control of, the commission for the purposes of the bill. The fund would consist of private donations and federal, state, and private grants. By creating a new continuously appropriated fund, this bill would make an appropriation.

~~Existing law contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs.~~

~~This bill would state the intent of the Legislature to enact legislation relating to mental health services.~~

Vote: majority. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

1 *SECTION 1. Part 3.4 (commencing with Section 5835) is added*
2 *to Division 5 of the Welfare and Institutions Code, to read:*
3
4 *PART 3.4. EARLY PSYCHOSIS DETECTION AND*
5 *INTERVENTION COMPETITIVE SELECTION PROCESS ACT*
6
7 *5835. (a) This part shall be known, and may be cited, as the*
8 *Early Psychosis Detection and Intervention Competitive Selection*
9 *Process Act.*
10 *(b) As used in this part, the following definitions shall apply:*
11 *(1) “Commission” means the Mental Health Services Oversight*
12 *and Accountability Commission established pursuant to Section*
13 *5845.*
14 *(2) “Early psychosis detection and intervention” refers to a*
15 *program that utilizes evidence-based approaches and services to*
16 *identify and support clinical and functional recovery of individuals*
17 *by reducing the severity of first, or early, episode psychotic*
18 *symptoms, keeping individuals in school or at work and putting*

1 *them on a path to better health and wellness. This may include,*
2 *but is not limited to, all of the following:*
3 *(A) Focused outreach to at-risk and in-need populations as*
4 *applicable.*
5 *(B) Recovery-oriented psychotherapy.*
6 *(C) Family psychoeducation and support.*
7 *(D) Supported education and employment.*
8 *(E) Pharmacotherapy and primary care coordination.*
9 *(F) Use of innovative technology for mental health information*
10 *feed-back access that can provide a valued and unique opportunity*
11 *to assist individuals with mental health needs and to optimize care.*
12 *(G) Case management.*
13 *5835.1. The Legislature finds and declares all of the following:*
14 *(a) Fifty percent of all mental illness begins by the age of 14*
15 *and 75 percent by the age of 24, yet young people are often afraid*
16 *to reach out for help.*
17 *(b) Psychotic symptoms, such as hallucinations, delusions,*
18 *unusual or disorganized behaviors or speech, and negative actions,*
19 *such as social withdrawal, usually emerge during late adolescence*
20 *or early adulthood and derail important developmental milestones,*
21 *such as developing relationships, completing school, or entering*
22 *the workforce.*
23 *(c) Approximately 100,000 adolescents and young adults in the*
24 *United States experience first episode psychosis each year.*
25 *(d) Untreated psychosis increases a person's risk for suicide,*
26 *involuntary emergency care, and poor clinical outcomes, and may*
27 *initiate a trajectory of accumulating disability into later adulthood.*
28 *(e) The average delay in receiving appropriate diagnosis and*
29 *treatment for psychotic disorders is 18.5 months following the*
30 *onset of psychotic symptoms.*
31 *(f) In the United States, people diagnosed with psychotic*
32 *disorders, such as bipolar disorder, major depression, and*
33 *schizophrenia, die an average of 11 years earlier than the general*
34 *population.*
35 *(g) Changing the paradigm from reactive to proactive early*
36 *detection and treatment has demonstrated efficacy and cost benefit*
37 *as recognized by the National Institute of Mental Health, the*
38 *federal Centers for Medicare and Medicaid Services, and the*
39 *federal Substance Abuse and Mental Health Services*

1 *Administration, along with documented outcomes from other states,*
2 *such as New York.*
3 *(h) According to numerous documented reports, including*
4 *analyses and research conducted by the federal Substance Abuse*
5 *and Mental Health Services Administration, and the National*
6 *Institute of Mental Health, evidence-based strategies have emerged*
7 *to identify, diagnose, and treat the needs of individuals with early*
8 *serious mental illness, including psychotic symptoms and disorders.*
9 *(i) Clinical research conducted worldwide, and within California*
10 *and the United States, supports a variety of evidence-based*
11 *interventions for ameliorating psychotic symptoms and promoting*
12 *functional recovery-oriented treatment, including cognitive and*
13 *behavioral psychotherapy, low doses of atypical antipsychotic*
14 *medications, family education and support, educational and*
15 *vocational rehabilitation, and coordinated care approaches to*
16 *case management.*
17 *(j) Empowering patients and families with innovative social*
18 *media and mental health information feed-back access that*
19 *harnesses advances in technology can provide a valued and unique*
20 *opportunity to assist individuals with mental health needs and to*
21 *optimize care.*
22 *(k) Comprehensive public and private partnerships at both local*
23 *and regional levels are necessary to develop and maintain*
24 *high-quality, patient-centered, and cost-effective care for*
25 *individuals experiencing psychotic symptoms or psychotic disorders*
26 *to facilitate their recovery and lead toward wellness.*
27 *5835.2. (a) There is hereby established an advisory committee*
28 *to the commission. Membership on the committee shall be as*
29 *follows:*
30 *(1) The chair of the Mental Health Services Oversight and*
31 *Accountability Commission, or his or her designee, who shall serve*
32 *as the chair of the committee.*
33 *(2) The director of the County Behavioral Health Directors*
34 *Association of California, or his or her designee.*
35 *(3) The director of a county behavioral health department that*
36 *administers an early psychosis detection and intervention-type*
37 *program in his or her county.*
38 *(4) A representative from a nonprofit community mental health*
39 *organization that focuses on service delivery to transition-aged*
40 *youth and young adults.*

1 *(5) A psychiatrist or psychologist.*
2 *(6) A representative from the Behavioral Health Center of*
3 *Excellence at the University of California, Davis, or a*
4 *representative from a similar entity with expertise from within the*
5 *University of California system.*
6 *(7) A representative from a health plan participating in the*
7 *Medi-Cal managed care program and the employer-based health*
8 *care market.*
9 *(8) A representative from the medical technologies industry*
10 *who is knowledgeable in advances in technology related to the use*
11 *of innovative social media and mental health information feed-back*
12 *access.*
13 *(9) A representative knowledgeable in evidence-based practices*
14 *as they pertain to the operations of an early psychosis detection*
15 *and intervention-type program, including knowledge of other*
16 *states' experiences.*
17 *(10) An at-large representative identified by the chair.*
18 *(b) The advisory committee shall be convened by the chair and*
19 *shall, at a minimum, do all of the following:*
20 *(1) Provide advice and guidance broadly on approaches to*
21 *early psychosis detection and intervention programs from an*
22 *evidence-based perspective.*
23 *(2) Review and make recommendations on the commission's*
24 *guidelines or any regulations in the development, design, selection*
25 *of awards pursuant to this part, and the implementation or*
26 *oversight of the early psychosis detection and intervention*
27 *competitive selection process established pursuant to this part.*
28 *(3) Assist and advise the commission in the overall evaluation*
29 *of the early psychosis detection and intervention competitive*
30 *selection process.*
31 *(4) Provide advice and guidance as requested and directed by*
32 *the chair.*
33 *5835.3. (a) The Early Psychosis Detection and Intervention*
34 *Fund is hereby created within the State Treasury and,*
35 *notwithstanding Section 13340 of the Government Code,*
36 *continuously appropriated to, and under the administrative control*
37 *of, the commission for the purposes of this part. The commission*
38 *may use no more than five hundred thousand dollars ($500,000)*
39 *of the amount deposited annually into the fund for administrative*

1 *expenses in implementing this part, including providing technical*
2 *assistance.*
3 *(b) There shall be paid into the fund all of the following:*
4 *(1) Any private donation or grant for the purposes of this part.*
5 *(2) Any other federal or state grant for the purposes of this part.*
6 *(3) Any interest that accrues on amounts in the fund and any*
7 *moneys previously allocated from the fund that are subsequently*
8 *returned to the fund.*
9 *(c) Moneys in the fund shall be used as one of the sources of*
10 *funding for the purposes of this part. Moneys shall be allocated*
11 *from the fund by the commission for the purposes of this part.*
12 *(d) Distributions from the fund shall be supplemental to any*
13 *other amounts otherwise provided to county behavioral health*
14 *departments for any purpose and shall only be used to augment*
15 *services and supports identified for the purposes of this part.*
16 *5835.4. (a) It is the intent of the Legislature to authorize the*
17 *commission to administer a competitive selection process as*
18 *provided in this part to create new, and to expand and improve*
19 *the fidelity of existing, service capacity for early psychosis*
20 *detection and intervention services in California.*
21 *(b) The core objectives of this competitive selection process*
22 *include, but are not limited to, all of the following:*
23 *(1) Expanding the provision of high-quality, evidence-based*
24 *early psychosis detection and intervention services within*
25 *California.*
26 *(2) Improving access to effective services for transition-aged*
27 *youth and young adults at high risk for, or experiencing, psychotic*
28 *symptoms, including the prodromal phase, or psychotic disorders.*
29 *(3) More comprehensively and effectively measuring*
30 *programmatic effectiveness and enrolled client outcomes of*
31 *programs receiving awards in the competitive selection process.*
32 *(4) Improving the client experience in accessing services and*
33 *in working toward recovery and wellness.*
34 *(5) Increasing participation in school attendance, social*
35 *interactions, personal bonding relationships, and active*
36 *rehabilitation, including employment and daily living function*
37 *development for clients.*
38 *(6) Reducing unnecessary hospitalizations and inpatient days*
39 *by appropriately utilizing community-based services and improving*

access to timely assistance to early psychosis detection and intervention services.

(7) Expanding the use of innovative technologies for mental health information feed-back access that can provide a valued and unique opportunity to optimize care for the target population.

(8) Providing local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for the target population, including transition-aged youth and young adults.

(c) Funds allocated by the commission for the purposes of this part shall be made available to selected counties, or counties acting jointly, through a competitive selection process.

(d) (1) Notwithstanding any other law, a county, or counties acting jointly, that receive an award of funds for the purposes of this part shall be required to provide a contribution of local funds. The local funds may include local Mental Health Services Act moneys and county general fund revenues.

(2) Upon approval of the commission, after consultation with the Department of Finance and the Department of Health Care Services, other locally acquired funding, such as federal grants or allocations, or other special funds, may also be recognized for the purpose of contributing toward any contribution requirements for the purposes of this part.

(e) Awards made by the commission shall be used to create, or expand existing capacity for, early psychosis detection and intervention services and supports. The commission shall ensure that awards result in cost-effective and evidence-based services that comprehensively address identified needs of the target population, including transition-aged youth and young adults, in counties and regions selected for funding. The commission shall also take into account at least the following criteria and factors when selecting recipients of awards and determining the amount of awards:

(1) A description of need, including, at a minimum, a comprehensive description of the early psychosis detection and intervention services and supports to be established or expanded, community need, target population to be served, linkage with other public systems of health and mental health care, linkage with schools and community social services, and related assistance as applicable, and a description of the request for funding.

(2) A description of all programmatic components, including outreach and clinical aspects, of the local early psychosis detection and intervention services and supports.

(3) A description of any contractual relationships with contracting providers as applicable, including any memorandum of understanding between project partners.

(4) A description of local funds, including the total amounts, that would be contributed toward the services and supports as required by the commission through the competitive selection process, implementing guidelines, and regulations.

(5) The project timeline.

(6) The ability of the awardee to effectively and efficiently implement or expand an evidence-based program as referenced in this part.

(7) A description of core data collection and the framework for evaluating outcomes, including improved access to services and supports and a cost-benefit analysis of the project.

(8) A description of the sustainability of program services and supports in future years.

(f) The commission shall determine any minimum or maximum awards, and shall take into consideration the level of need, the population to be served, and related criteria as described in subdivision (e) and in any guidance or regulations, and shall reflect the reasonable costs of providing the services and supports.

(g) Funds awarded by the commission for purposes of this part may be used to supplement, but not supplant, existing financial and resource commitments of the county or counties acting jointly, that receive the award.

(h) The commission may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, initiate an interagency agreement with another public entity, including the University of California system, or contract for necessary technical assistance to implement this part.

5835.5. The commission may adopt guidelines or regulations, in consultation with the advisory committee established in Section 5835.2, as well as other stakeholders as necessary, to exercise the powers and perform the duties conferred or imposed on it by this part, including defining eligible costs and determining minimum and maximum awards under the competitive selection process and any stipulating conditions. Any guideline or regulation adopted

1 *pursuant to this section shall not be subject to the requirements*
2 *of the Administrative Procedure Act (Chapter 3.5 (commencing*
3 *with Section 11340) of Part 1 of Division 3 of Title 2 of the*
4 *Government Code).*
5 ~~SECTION 1. It is the intent of the Legislature to enact~~
6 ~~legislation relating to mental health services.~~

O

Assembly Bill 1315

Early Psychosis Detection and Intervention Funding

Assembly Member Mullin

PURPOSE

The purpose of AB 1315 is to address an unmet need to provide evidence-based early psychosis detection and intervention services and supports to transition-aged youth and young adults who are at-risk of, or experiencing, psychotic symptoms or have psychotic disorders.

Fifty percent of all mental illness begins by the age of 14 and 75 percent by the age of 24, yet young people are often reluctant and afraid to seek help. Approximately 100,000 adolescents and young adults experience first episode psychosis each year.

Untreated psychosis increases a person's risk for suicide, involuntary emergency care, poor clinical outcomes, and can initiate a trajectory of accumulating disability into later adulthood. The average delay in receiving diagnosis and treatment for psychotic disorders is 18.5 months following the onset of psychotic symptoms.

Clinical research conducted world-wide supports a variety of evidence-based interventions for ameliorating psychotic symptoms and promoting functional recovery-oriented treatment.

Changing the paradigm from reactive to proactive early detection and treatment has demonstrated efficacy and is cost-beneficial as recognized by the federal SAMHSA and the National Institute of Mental Health, as well as independent evaluators. The principal goal is to intervene early, and to improve the client experience in accessing services and working towards lasting recovery and wellness.

SUMMARY

AB 1315 will serve as a catalyst to invigorate evidence-based practices and will address a significant unmet gap in California's delivery system for transition-aged youth and young adults.

AB 1315 establishes a special fund and a competitive selection process to make awards as specified to create new, and expand existing, evidence-based early psychosis detection and intervention services and supports.

The Early Psychosis Detection and Intervention Fund will be created for the purpose of private donations, and the deposit of other federal or state grants as applicable. Awards from this fund will be made according to a competitive selection process across interested County Behavioral Health Departments. Awardees will meet specified requirements for evidence-based services and supports, and provide a contribution of local funds, such as local Mental Health Services Act funds.

This private-public partnership is new and integral to achieving innovation in mental health care services for this very vulnerable target population.

The Mental Health Services Oversight and Accountability Commission (Commission) will administer the competitive process with the expertise and assistance of an Advisory Committee.

A key aspect of AB 1315 is a focus on outcome oriented, evidence-based practices, with a designated evaluation framework as a component to the competitive selection process.

EXISTING LAW

Existing law provides for the following:

(1) The Medi-Cal Program under which County Behavioral Health Departments provide specialty mental health services, including those offered under the Early and Periodic Screening, Diagnoses, and Treatment (EPSDT) Program (0-21 years). EPSDT provides services to eligible individuals who are diagnosed with experiencing serious emotional disturbance. This area of law primarily operates under a 1915b federal Waiver which, among other things, enables County Behavioral Health Departments to operate as Prepaid Inpatient Health Plans.

(2) The Mental Health Services Act provides funding and a framework for community-based programs in the areas of innovation, prevention and early intervention, and community services and supports. Generally, funds are allocated to counties base upon formulas with County Behavioral Health Departments administering programmatic components of the service delivery system. The Mental Health Services Oversight and Accountability Commission (Commission) provides oversight.

(3) The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides a small amount of federal funding for the support of certain mental health and substance use disorder services. A portion of this amount is designated for early psychosis detection and intervention programs.

Existing law does not directly address in any comprehensive manner the specific need for evidence-based early psychosis detection and intervention services and supports, or funding for it comprehensively.

SOLUTION

AB 1315 provides a unique opportunity to incentivize County Behavioral Health Departments to address a glaring gap in services for California's transition-aged youth and young adults. Implementation of the Early Psychosis Detection and Intervention Fund and the competitive selection process would provide cost-beneficial, evidence-based services and supports to a target population in need. Funds will be available and programmatic components are known for implementation to be successful.

SUPPORT

Steinberg Institute

CONTACT

Hugh Bower. Chief of Staff
Assembly Speaker Pro Tempore Kevin Mullin
(916) 319-2022

AGENDA ITEM 5

Action

April 27, 2017 Commission Meeting

Technical Assistance Contract

Summary: The Executive Director is requesting approval from the Commission to enter into a contract with Alexan Risk and Project Management Advisory Services (RPM) for technical assistance in business processes and information technology services. Consultants from Alexan will assist Commission staff in developing the following:

- **Budget and Accounting Self-Sufficiency Project:** Improve MHSOAC's access to and control of budgeting and accounting information to establish confidence that finances are being managed responsibly and in a timely fashion

- **Data and Technology Self-Sufficiency:** Create in-house capacity to develop and maintain MHSOAC's evolving data environment and prepare the necessary processes, governance and technology to articulate MHSA outcomes. Establish MHSOAC data architecture and management processes that span the information needs of the organization. Prepare the environment for the arrival of the in-house data base administrator.

- **MHSOAC Office Automation Improvement:** MHSOAC plans for improvement in its internal capabilities and capacities regarding internal workflow processes and data sharing. Tasks for this initiative include analyzing alternatives and developing a plan for revising the current MHSOAC office automation environment by adopting Microsoft Office 365G, implementing Microsoft Active Directory and automated workflow / approvals, creating a shared data repository with enhanced capabilities and effective file organization, and establishing digital signature capability, via SharePoint.

- **Analytical Tool study:** Establish internal requirements for type and variety of data analytics tools that will enable MHSOAC staff to analyze a variety of data sets from partnering organizations throughout the state and help determine the improvement in the lives of the individuals whom receive services funded via MHSA.

- **Compliance Update:** Maintain compliance with all state organizational and IT requirements. (i.e.; business resumption; IT disaster recovery; IT reporting; contracts management; IT security, etc.).

- **Triage data collection:** Establish process and tools needed to gather, store, analyze and report activities funded through the Triage Grant process.

- **Project and Portfolio Management Services:** Much of what MHSOAC is currently doing is project-based; the effort has a specific start, a specific end and a unique outcome. The Fiscal Transparency Tool, Nami+, FSP, PPS, DCR/CSI data acquisition, DOJ data linkage, Office 365G migration, Grants Management, innovation projects, and live stories are all examples of project work that is planned for the upcoming fiscal year.

Enclosure: None

Handout: A PowerPoint will be provided at the meeting.

Recommended Action: MHSOAC Staff recommends approval of the contract with Alexan Risk and Project Management Advisory Services (RPM).

Presenters:
Brian Sala, Deputy Director; Norma Pate, Deputy Director, MHSOAC

Motion: The Commission approves the contract with Alexan Risk and Project Management Advisory Services (RPM) to provide technical assistance in business processes and information technology and authorizes the Executive Director to enter into a contract for up to $500,000.

AGENDA ITEM 6

Action

April 27, 2017 Commission Meeting

MHSA Fiscal Reversion Report

Summary: The Commission will consider a draft report prepared by the Fiscal Reversion Policy Project Subcommittee. Under the Mental Health Services Act, funds allocated to each County must be spent within their specified components (Community Services and Supports; Prevention and Early Intervention; and Innovation) within three years of distribution, unless transferred to the County's MHSA Prudent Reserve or reserved for expenditure in other, allowable MHSA categories. Funds not spent or transferred within these time constraints are to be "reverted" to the State Mental Health Services Fund (State Fund) for redistribution to other counties.

The Department of Health Care Services indicates that no funds have reverted to the State fund since 2008. Various stakeholders have raised concerns that the statute was not being appropriately enforced and that substantial funds should have reverted to the State Fund.

The Commission adopted this project in 2016 to clarify the status of unspent funds in the counties, better understand both why counties have retained unspent funds and why certain funds have not reverted to the State for redistribution, and develop recommendations to resolve outstanding concerns. The Subcommittee approved the draft report on March 20, 2017, for presentation to the Commission.

This report finds that for MHSA funds distributed in and subsequent to Fiscal Year 2012-13, most counties appear largely to have met expectations for timely expenditure of MHSA funds. However, many counties have retained some unspent funds from 2011-12 and prior years that appear to be subject to fiscal reversion to the State Fund. Based on the Commission's preliminary calculations, unspent funds subject to reversion amount to approximately 1.6 percent of the more than $6.9 billion MHSA funding allocated to the counties through FY 2011-12, or roughly $112 million. These dollars have accrued for a variety of reasons, including a lack of clarity in whether and how to return unspent funds to the State Fund. The report identifies several options for consideration by the Legislature and the Administration for resolving these concerns.

Presenter: Brian R. Sala, Ph.D., Deputy Director for Evaluation and Program Operations.

Enclosures: None.

Handouts (2): (1) Draft Report: *Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities*. (2) A PowerPoint overview of the report will be presented.

Proposed Motion: The MHSOAC adopts the report: *Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities*.

AGENDA ITEM 7

Action

April 27, 2017 Commission Meeting

Modoc County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Modoc County's request to fund a new Innovative project: electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD) for a total cost of $364,896 in Innovation component funding over four (4) years. Modoc County proposes to bring three strategies together with their innovation plan with a web-based, flexible data system; an implementation method; and data training to improve using data to drive clinical practice.

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 eBHS IITD Innovation project will be implemented through a contract with California Institute for Behavioral Health Solutions (CIBHS) and purchasing the technology and equipment for the web-based data collection system. Some of the Innovation funding will support portions of the Modoc County Clinical Director, Administrative Assistant, and MHSA Project Manager.

Presenters:

- Karen E. Stockton, PhD, MSW, BSN, Health Services Director

Enclosures (2): (1) Staff Summary, electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD), County Innovation Brief

Handout (2): (1) County Power Point

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/2017-04/modoc-county-inn-description-electronic-behavioral-health-solutions-and-feedback

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

Name: electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD)
Amount: $364,896
Project Length: Four (4) Years

Bio for Modoc County Innovation Presenter

Karen Stockton, Ph.D., M.S.W., B.S.N, has served as the Health Services (HS) Director for the County of Modoc since June 1, 2006. As HS Director, she also services as Director of Behavioral Health Services and is responsible for oversight of the MHSA service planning and service delivery. As a part of the County Behavioral Health Association of California (CBHDA) she serves as the Chair of the Superior Region Committee. She has also served on the CalMHSA SEE Team and the MHSOAC Evaluation Advisory Committee. Prior to coming to Modoc County, she was Chair of the Department of Social Work at Andrews University, Berrien Springs, MI. She received her Ph.D. in Leadership in 2003. She has worked for almost 50 years in the field of nursing, health education, community services, social work, mental health, social justice advocacy and policy development.

STAFF INNOVATION SUMMARY — MODOC COUNTY

Name of Innovative (INN) Project: electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD)

Total INN Funding Requested for Project: $364,896

Duration of Innovative Project: Four (4) Years

Review History

Approved by the County Board of Supervisors: April 11, 2017
County Submitted Innovation (INN) Project: March 6, 2017
MHSOAC Consideration of INN Project: April 27, 2017

Project Introduction:

Modoc County proposes using Innovation funds to purchase a three-pronged approach designed by the California Institute for Behavioral Health Solutions (CIBHS, formally known as CIMH) for data collection to improve client outcomes. The three-pronged approach is (1) a web-based, flexible data system, (2) a unique and advanced implementation planning method, and (3) use data training for treatment and client supports. The County plans to contract out the training, evaluation and technical assistance component of the Innovation project to CIBHS and the technology for the data collection system to another contractor and off-set some of the County administrative salary for the project through Innovations.

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

Modoc County states this Innovation project is needed to increase data analytic capabilities for mental health clinicians to bring about increases in treatment quality, enhance mental health services, and improve consumer retention which leads to better

outcomes. Like other behavioral systems, Modoc expresses the benefit of using technology in mental health treatment, support, and data collection as a prerequisite and necessity to help physicians, clinical staff, family members, community support personnel, and researchers obtain new ways to access help, monitor client and consumer progress, and increase understanding of mental wellbeing. According to the County, the web-based data system has data structures and processes to accomplish designing graphs, pattern matching, priority queues, sorting, and much more in a user friendly way. It is flexible to provide signals to the clinical staff and easily transportable, making it a good fit for the remote populations of Modoc County. The County also states their electronic health record system has been able to support quality improvement goals for documentation and billing, but it does not allow for meaningful discovery of patterns in service needs and best practices for the clients served.

The Response

Modoc County states they have been working with CIBHS for the past two years to determine a method to improve data collection. They state they currently face resistance from clinicians struggling to see the value of outcome measures to drive clinical decision-making. The County has also spent five years in multiple Plan-Do-Study-Act cycles to determine a better collection system. This assessment tool has been used by other counties facing similar barriers and issues, with some demonstrating success in improving data collection and analytics.

Through the Mental Health Services Act, CIBHS has been able to offer many counties technical assistance, training, and development of dashboards to implement best practices for the administration of outcome measures. Counties have used these dashboards to determine treatment options and clinical effectiveness of evidence-based practices along with sharing data collection with clinicians and consumers. This has been successfully seen with the data collection recommendations brought by organizations like CIBHS for Full-Service Partnerships and Prevention and Early Intervention programs. The electronic Behavioral Health Solutions (eBHS) will utilize what appears to be the same outcome measures and data collection schedule as used by other counties under PEI. This has been used successfully for certain evidence-based practices implemented by counties during the roll-out of PEI. Modoc may wish to discuss how the proposed dashboard differs from ones used through MHSA FSP and PEI programs or what new value the clinical dashboard will bring to the mental health field.

According to the County, the second component of the Innovation project utilizes CIBHS' Community Development Team (CDT) model. The CDT model is an approach used by other county mental health departments, community-based organizations, and foundations to train and strategize adherence to an innovative program or operation. The model uses clinical and technical trainings, planning process, peer-to-peer support and outcome/evaluation support to help an organization adopt a different way of addressing something facing implementation barriers. The County may wish to discuss the decision to not utilize the MHSA Workforce Education and Training component for this approach and how it will bring value to the mental health field given its history of established positive outcomes in other counties.

According to the County, the third component of the approach will use the Feedback Informed Treatment approach, a program designed by Scott Miller, PhD, to train clinicians on how to use outcome data collected from consumers to drive clinical practice. The County states this is new for their clinicians because using data in practice has not been done by their clinical staff. This practice of data driven clinical care has been at the forefront of good clinical practice in many service oriented industries such as health care, mental health care, and trauma-informed care.

It appears the three-pronged approach presented in this Innovation project is a combination of established and successful methods to improve timely access to clinical data, a clinical dashboard to exchange data, and technical assistance and training to engage the end-user of the system; in this case- clinicians. The approach follows what other data collection systems have offered, including: convenience, privacy, a technological platform, cost-effectiveness, 24-hour availability to data, support, and effectiveness. It may be this three-pronged approach is facilitating a multi-site collaboration, training, and data analysis. It is unclear if the three approaches have been used in any other county simultaneously and just not been in such close collaboration as is being proposed in this project.

The Community Planning Process

The MHSA regulations indicate 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 for meeting this requirement.

The County reports utilizing the Three-Year and Annual planning process requirements to obtain stakeholder input. The County states they held focus groups, provided mental health policy training, embraced diversity (by having representatives from the following groups: Native Americans, Veterans, consumers, family members, law enforcement, health centers, social services, and more), and promoted using media and outreach along with websites to advertise the meetings. The County reports they will be seeking stakeholder feedback throughout the implementation of the project as part of the decision-making and evaluation 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 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.

The County objective with selecting this innovation project is to increase the clinicians' use of data, the administrative use of data, and the availability of more real-time data. The County has provided the proposed pre- and post-survey methodology to determine

if providing the three-pronged approach to a group of clinicians does lead to increase use of data to drive clinical care. According to the County, CIBHS will provide ongoing technical assistance and completing majority of the evaluation. The total budget for the contractor is $174,682, of which 7% is allocated to evaluation (or $12,228 total for four years). The County states the ongoing cost of the system, if they choose to continue, will be covered by Realignment or MHSA CSS funds.

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? Following is the proposed budget county budget and duration of INN project.

The County is requesting $364,896 for four years to be approved for Innovation. As a side note, the County intends to add in-kind funds from 1991 Realignment, FFP, or Behavioral Health Subaccount to add to the project's total budget. The County states the estimated total budget for the project is $676,347.

The budget for the consultant, CIBHS, is $174,684 (or ~48% of the total budget), to provide the training, technical assistance and evaluation for the Innovation project. The evaluation budget is 7% (or $12,228 total for four years) of the contractor's budget. The non-recurring operating costs total $105,000 (~29% of the total Innovation budget) to support the system set-up, configuration, and equipment for the eBHS web-based data collection system.

$85,212 (~23% of the total Innovation budget) is set aside for personnel cost for:
- 0.1 FTE Modoc County Clinical Director - $8,801 per year
- 0.25 FTE Modoc County Administrative Assistant/Analyst - $9,002 per year
- 0.1 Modoc County MHSA Project Manager - $3,500 per year

Additional Regulatory Requirements

The proposed project meets minimum regulatory requirements as stated in MHSA Innovation regulations. The County made a change to the total budget of the Innovation project and will be seeking a secondary approval by the Board of Supervisors on the change to the budget on April 25, 2017.

References

Measure (FRIFM) and Instructions ICCE Manuals on Feedback-Informed Treatment (FIT) 2012, International Center for Clinical Excellence, Bob Bertolino and Scott D. Miller, Series Editors for ICCE Manuals.
http://scottdmiller.com/wp-ontent/uploads/FRIFM(1).pdf

Modoc County Innovations Project Overview – 4/27/17
Electronic Behavioral Health Solutions (eBHS)
Innovations and Improvement Through Data (IITD)

Over the past five years, Modoc County has been participating in integrated care learning collaboratives that incorporated quality improvement (Plan, Do, Study, Act – PDSA) processes. Learning from the PDSA cycles included the following barriers and/or needs:

1) Electronic health records (EHRs) and State reporting systems do not adequately contribute to real time use of data for partnering with clients in treatment planning nor tracking adherence and use of evidence based practices nor are they useful for tracking individuals not formally admitted for services, therefore they are not useful for beneficiary/population management;

2) There is a critical need for a data analytic system to meet multiple data needs, including day-to-day clinical dashboards, population management data reports, and aggregate outcomes reporting for internal and external stakeholders. The data system should have the capacity to pinpoint and allow for data analysis and improved system response thus improving behavioral health care in this especially small "frontier" County;

3) Most counties have not been successful in spreading the use of data analytics systems beyond special projects, much less for population management. Any system adopted needs to have a strong implementation process aimed at embedding the data analytics as a part of the clinical practice and easy to use with minimal information technology support;

4) The implementation process needs to engage and educate staff in practical, real-time use of data in treatment planning and tracking individual outcomes related to selection of and adherence to evidence-based or promising practices;

5) Once these are incorporated, the data analytics system should have the flexibility to allow for entry of individuals not registered in the EHR, have ability to accept data crosswalk from the EHR and/or other data systems, have data collection reminders, allow access for integrated care partners, and have potential for client portal capability in the future.

Through the proposed innovation, Modoc County would bring three effective strategies together to improve client outcomes and manage the Behavioral Health population more proactively. This three-pronged approach was developed by the California Institute for Behavioral Health Solutions (CiBHS) to increase the success of data collection initiatives. If awarded Innovation funding, **Modoc would be the first county to utilize it for system-wide data collection, client outcome tracking, population management, and quality improvement.** The proposed approach includes: 1) a uniquely flexible, cost-efficient web-based data analytic system; 2) a strong implementation method; and 3) training on use of data in clinical practice and for population management. Each component is believed to be equally essential.

Equal attention to these three components will result in staff and clinicians knowing how to navigate the data system, add data for population management, understand how to interpret outcomes data in clinical dashboards, and sustain use of data long-term so it becomes a natural part of clinical practice and managed care. The ultimate goal of this

innovative project is a sustained improvement in client outcomes. The three pronged approach (IITD) will be as follows:

1. The Data System— electronic Behavioral Health Solutions (eBHS):

A flexible, cost-efficient web-based platform, eBHS enables custom development of reports including clinical dashboards, aggregate outcomes reports, and population management reports. Clinical dashboards will be developed based on clearly defined clinical outcomes: 1) A Global Functioning Measure; 2) Treat-to-Target measures. Real time data will be used to engage the client and clinician in treatment to ensure the best possible outcomes. In addition, eBHS will be set up to aggregate pre and post outcomes data with filtering options providing the ability to collect data based on common demographics categories, such as race, gender, age, etc.

2. The Implementation Protocol:

We will use the Community Development Team model (CDT) based on implementation science and developed by CiBHS in 2006. Used in California to implement Evidence-Based Practices and Community-Defined practices, the CDT will be modified for this innovation to include specific pre-implementation activities related to the use of technology and preparation for using data in real time to guide clinical practice and population management. Modoc County will participate in peer-to-peer calls with clinical and implementation staff of other counties to share learning, challenges, and barriers.

3. Data Interpretation and Feedback Informed Treatment (FIT)Training:

The staff using eBHS will receive specific training on how to interpret and use clinical outcomes data with clients to inform practice. By integrating trainings of eBHS and FIT, eBHS will be presented as a clinical tool rather than a database. Further, the process will build capacity as a Managed Care Entity to use eBHS as a population management tool.

Learn and Improve

Modoc County aims to learn and improve client service through the implementation of a new population management/data analytics system in two areas:

Goal 1: Increase clinician use of real-time data analytics. The goal is that clinicians will incorporate review of data as a natural and integral part of service delivery through use of eBHS.

Goal 2: Implement system-wide administrative use of data analytics. Small counties have minimal opportunity to analyze their data to better understand treatment and outcomes, and for use in population management and prevention. This innovation will help Modoc County better understand what may be impacting areas of concern throughout their system as well as the potential to be used in an integrated manner with all areas of whole-person health and for proactive prevention and linkage to treatment. Modoc County would be, to our knowledge, the first county mental health plan in California to implement eBHS or other population management analytics tool system wide. Since we are a pilot county for eBHS, our intent is to make our learning available to other counties for their use. The initial implementation is intended to serve as a foundation for further proactive prevention population management and potential interface with other databases for upstream prevention and early intervention.

Community Program Planning

The Modoc County Behavioral Health (MCBH) Community Program Planning (CPP) process for the development of this Innovation Component Plan was based upon the three-year planning process for the FY 2014/15-2017/18 MHSA Plan (approved March 2015) and the FY 15-16 and FY 16-17 Plan Updates. The process was comprehensive and included the input of diverse stakeholders through one-on-one discussions, formal focus groups, stakeholder meetings, and surveys. The plan was posted 3/3/ - 4/2/17 for public comment and a Public Hearing was on 4/3/17. The Board of Supervisors approved the Plan on 4/11/17.

Primary Purpose

The purpose of this proposal is twofold: 1) to increase the data analytics capabilities of Modoc County and to determine how to assist other small counties in the adoption of data analytics; and 2) to impact the quality and retention of services, including better outcomes through real-time data use by clinicians and consumers and proactive population management.

Innovative Project Category

This project will <u>introduce a new mental health practice or approach</u> by addressing three areas: A flexible data system, Implementation planning and sustained support, and training on how to interpret individual and population data and use this information to guide prevention and treatment.

Setting/Population

Modoc County is the third smallest county in the state of California with a population of 9,686 with a population density of about 2 people per square mile (2010 census). We are one of the most isolated, rural counties with 2 critical care access hospitals and clinics and 3 other rural clinics for primary care. Residents must travel about 150-180 miles, often out of State, to access specialty medical care. There is no psychiatric inpatient care in the county. The fully integrated **Behavioral Health** team consists of 21.5 full time equivalent staff members (3 FTE Administration, Administrative Support 7 FTE, and 11.5 FTE Direct Services Staff). Telemedicine is provided under contract for Psychiatry and prescribing of psychotropic medications. This BH team was responsible for the managed care of and service delivery to 531 unduplicated individuals in FY 15-16 (432 MH and 82 SUDS).

Community Collaboration

The proposed project comes from several years of stakeholder input and collaboration among County Policy Makers, Agency Directors and department Heads, direct service staff, consumers and their family members. Modoc Community Corrections Partnership (CCP) has representation including the Director of Health Services, the Deputy Directors of Public Health and Behavioral Health, the Alturas Police Department chief, the Modoc County Sheriff, District Attorney, Public Defender, Director of Social Services and the presiding court judge. Also included are directors and representatives of Community Based Organizations that provide direct services to the target population. Working collaboratively is a fundamental value in our community

and the quality of our collaborative partnerships is a special strength in our small, isolated community. This proposal addresses our partnerships' shared perceptions of unmet needs and barriers to fostering prevention, wellness and recovery. One of the priority barriers identified is that we do not have a **shared data analytics system** to proactively manage the target population and collaboratively measure outcomes.

Evaluation

Evaluation is built into this innovation plan at every phase. Data will be collected by those trained in the use of eBHS pre and post training (6 and 12 months after training). It will include data from EHR, eBHS, quantitative and qualitative (client feedback data written or verbal). The Administrative Team will meet regularly with the CiBHS Team for project coordination. Staff will be constantly working in partnership with the CiBHS Team throughout life of the project. Project resources will be utilized primarily to pay for access to eBHS, for implementation of the use of eBHS data warehouse, and use of resulting data. We will have ongoing access to evaluation of the project.

Communication and Dissemination Plan

Information will be disseminated through a collaborative evaluation process, reporting findings to the BH Advisory Board and Staff, attaching a summary of findings to the Annual Plan update and reporting findings to CBHDA and the Small Counties Committee as appropriate. The CiBHS will share our evaluation data with other counties considering the use of eBHS or another population management system. Clients and other stakeholders will be involved in the use and evaluation of eBHS on an ongoing basis.

Budget

The County is requesting **$364,896 for four years** to be approved for Innovation (4 years - 5/01/2017 to 4/30/2021)

The budget for the consultant, CIBHS, is $174,684 (or ~48% of the total budget), to provide the training, technical assistance and evaluation for the Innovation project. The evaluation budget is 7% (or $12,228 total for four years) of the contractor's budget. The non-recurring operating costs total $105,000 (~29% of the total Innovation budget) to support the system set-up, configuration, and equipment for the eBHS web-based data collection system. $85,212 (~23% of the total Innovation budget) is set aside for personnel cost for:

- \- 0.1 FTE Modoc County Clinical Director - $8,801 per year
- \- 0.25 FTE Modoc County Administrative Assistant/Analyst - $9,002 per year
- \- 0.1 Modoc County MHSA Project Manager - $3,500 per year

Additionally, the County intends to add in-kind funds from 1991 Realignment, FFP, MHSA PEI or Behavioral Health Subaccount to add to the project's total budget to cover additional staff salary and benefits (to implement the registry and contribution to the evaluation process), associated Administrative and Direct and Indirect Operating Costs at an estimated in-kind budget of $311,453. The estimated total budget for the project is $676,349. If eBHS is judged to be effective, the ongoing cost of the access to eBHS will be covered by realignment and/or MHSA CSS funding administrative costs.

AGENDA ITEM 8

Action

April 27, 2017 Commission Meeting

Kern County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Kern County's request to fund a new Innovative project: Special Needs Registry – Smart911 for a total of $3,170,514 in Innovation component funding over five (5) years. Kern County proposes to increase interagency collaboration and reduce injury or death of mental health clients and law enforcement officers when responding to mental health crisis by making available to law enforcement officers information consumers living with mental illness have voluntarily inputted on their profile to better assist the officers, themselves and/or family members when responding to a crisis situation.

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.

Staffing for the project includes (2) Law Enforcement Lieutenants (.5 FTE) hired by the local sheriff and police department, County Program Specialist (1.0 FTE), County Administrative Coordinator (.25 FTE), a County Senior Information Systems Specialist (.10 FTE). The evaluation services will be contracted and through in-house County staff. The INN project appears to meet the minimum Innovation regulations.

Presenters:

- William Walker, LMFT, Director of Kern Behavioral Health and Recovery Services

Enclosures (2): (1) Staff Innovation Summary, 911 Special Needs Registry-Smart911; and (2) 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/2017-04/kern-county-inn-description-special-needs-registry-smart-911

Proposed Motion: Pending Kern County's Board of Supervisors approval the MHSOAC approves Kern County's Innovation plan as follows:

Name: Special Needs Registry - Smart 911

Amount: $3,170,514

Project Length: Five (5) Years

Kern County Presenters Bio

Bill Walker, Director of Kern Behavioral Health and Recovery Services has worked in mental health for over 30 years; beginning as a hotline volunteer. He has served children and adults in both inpatient and outpatient settings, assuming the role of director in 2013.

STAFF INNOVATION SUMMARY—KERN COUNTY

Name of Innovative (INN) Project: 911 Special Needs Registry-Smart911

Total INN Funding Requested for Project: $3,170,514

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: Pending MHSOAC approval

County Submitted Innovation (INN) Project: January 31, 2017

MHSOAC Consideration of INN Project: April 27, 2017

Project Introduction:

Kern County proposes to purchase the Smart911 technology to help local law enforcement interact with individuals living with mental health issues who seek assistance through their local emergency number. In support of this technology, the County plans to hire: two 0.5 FTE Law Enforcement Lieutenants (to be placed at a local police station), 1.0 FTE Kern Behavioral Health and Recovery Services (BHRS) Program Specialist II, 0.25 FTE Administrative Coordinator, and 0.10 FTE Senior Information Systems Specialist.

In the balance of this brief we address specific criteria the OAC looks for when evaluating Innovation Plans, including: What is the unmet need 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 and that the proposed project must align with the core MHSA principles, promote learning, fund exploration of a new and/or locally adapted mental health approach/practice, and target one of the four allowable primary purposes.

The Need

The Kern County's Innovation plan states first responders, primarily law enforcement, are often the first point of contact for persons experiencing a mental health crisis, leading them to incarceration or hospitalization rather than de-escalation or diversion to services.

It has been a goal of many counties facing similar issues to support changing the culture

of police responding to persons having a mental health crisis. Counties have deployed other techniques such as avoiding sirens, loud voices, and an authoritarian demeanor in favor of a low key supportive approach; utilizing mental health services when appropriate rather than arrest and incarceration; emphasizing the importance of information gathering, and using all available information about the person to decide an appropriate course of action. These alternate approaches have come forward through programs such as SB 82, Prevention and Early Intervention, AB 109, and other initiatives.

The County states that they have challenges sending qualified mental health staff to mental health emergencies due to the severe shortage of mental health professionals and the county's large area of 8,136 square miles. The County explains this creates dependence on law enforcement as first responders in these situations. The County may wish to share more information on how this project was identified as a high need project, in particular how Kern County compares to other counties with frequencies of ER visits related to behavioral health needs. When reviewing the Office of Statewide Health Planning and Development (OSHPD) data, it appears Kern reported 423 ER encounters (0.13 percent) ended with a discharge/transfer to a psychiatric hospital or unit for ongoing care. The same data source states the statewide percentage is 0.77. One interpretation could be Kern County's level of psychiatric calls appears to be relatively low in comparison the other counties. Furthermore, other counties with similar needs have applied the MHSOAC Triage Grant to implement joint crisis response teams consisting of law enforcement and a mental health professional to help improve the kind of response provided when the crisis call involves an individual living with mental illness. Kern County may also wish to discuss how other program opportunities such as Senate Bill 82 could not address this need for Kern County.

The County also states they have not been able to successfully establish coordination of crisis interventions between law enforcement and mental health providers and believe providing funding to law enforcement to hire staff to manage this registry will create more coordinated services.

The Response

Kern County proposes to promote interagency collaboration related to mental health services, supports, or outcomes by implementing the Smart911 technology. Individuals living with mental illness and their families can voluntarily provide information that they feel will assist the officers, themselves, and/or family members when responding to a crisis situation in this online registry system, Smart911. The information inputted can include the individual's health information, medical issues, disabilities, mental health issues, photos, other physical descriptors, emergency contacts, and even floor plans of one's place of residence.

According to the developer (Rave Mobile Safety), this system has been successfully used through partnerships with public safety agencies in 41 states and more than 1500 municipalities, including Washington, D.C., Seattle, Atlanta and Denver, to allow citizens the ability to create the safety profile to provide valuable information to those dispatching providers for emergency/crisis care. According to Rave Mobile Safety, the project is the

first partnership between Rave Mobile Safety and a mental health agency, Kern County Behavioral Health services, instead of directly with Kern County's public safety agencies, as seen in other successful programs throughout the nation. In turn, Kern County Behavioral Health will give Innovation funding to the Bakersfield Police department and Kern County Sheriff's department to cover half the salary for a new Lieutenant each to support the public agency partner. It appears then, like other successful programs, through the contract with the mental health agency, Rave Mobile Safety will still be working closely with the public safety agencies in Kern County. The County may wish to discuss how this proposal brings a new idea from a non-mental health setting given it has been used by other states and municipalities to address similar needs but just through a direct partnership with public safety as oppose to what appears to be a joint partnership between mental health and public safety.

Like Cook County, Illinois, known for identifying best practices for jail diversion programs, Kern County will use officers trained in Crisis Intervention Training (CIT), through another funding source, for this project. What appears to be different is (1) the concentrated effort on developing out the mental health fields of the profile, (2) the focus on providing access to the tool at mental health treatment locations, and (3) the option of providing support to the consumer or family member by a mental health staff when completing the profile at the mental health treatment location.

The Smart911 registry tool is voluntary and will be available in the lobbies of forty (40) treatment locations. Staff, not funded through Innovations, will be trained and available to assist consumers in creating a registry. The registry can also be self-completed, or used by calling an over-the-phone assistance line from a home computer. The proposed Innovation Project will provide software and training to all fire departments, police departments and sheriff substations in Kern County. End user training will also be provided to dispatchers and first responders of all of these agencies.

The Community Planning Process

The MHSA regulations indicate 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 for meeting this requirement.

While it appears the development of this proposal was initially generated by stakeholder groups highly representative of first responders in the CIT Steering Committee meetings, the County provided many opportunities for commentary on the plan through hosting sixteen (16) meetings at different locations across the County and involving roughly three hundred and twenty five (325) individuals. According to Kern, those in attendance identified themselves as recovering from mental illness, family members, mental health providers, representatives from law enforcement and the criminal justice system, representatives from schools, medical providers, NAMI representatives and community based organizations.

A brief description of this project was included in the 2016-2017 Annual Update, which was posted for 30-day public comment and approved by the Behavioral Health Board. The County has shared they realized they did not place the full innovation plan for public review and provided the full plan for 30-day public review starting on April 6, 2017. The full Innovation plan also has not been approved by their Board of Supervisors. The MHSOAC suggests the County discuss the information provided for to the public for review and how the County did their due diligence to consider any recommendations which comes forward from the review. The County may also wish to inform the Commission of any significant recommendations which comes forward from the public comment period which may lead to changes to the plan and the need to re-present to the Commission the revised Innovation plan. The County will also need to inform the Commission when Board of Supervisor approval is obtained.

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.

Kern proposes an evaluation approach utilizing satisfaction surveys, feedback surveys, reports obtained from the technology company (Rave Mobile Safety) on the number of times Smart911 registry information is used, and how many clients utilize the Smart911 registry based on tracking in the County's electronic health record. The focus and sources of data appear to be limiting given the County's proposed outcomes of reducing injury or death occurring during an encounter with law enforcement. It does not link utilizing the Smart911 registry to current arrest/incarceration and hospitalization rates of the individuals with Smart911 profiles. This level of analysis could be valuable and impactful, however the County is focusing on reporting out how many clients register and theirs and law enforcement's satisfaction with the online tool. The County may want to consider a more robust evaluation expanding beyond satisfactory surveys to provide additional value to the mental health field.

Kern County anticipates contracting out the evaluation services. Information will be collected by staff from multiple agencies and provided to the contract evaluator who will analyze and report on the data. $35,000 per year has been allocated in the budget for the evaluation contract. An additional budget is allocated to set up the interface on the Smart911 kiosks to collect customer satisfaction data. The total evaluation budget for this project is $223,270, which is about 7% of the total Innovation funding request. The County is also requesting Innovation funds for a 0.25 FTE County Administrative Coordinator to also support evaluation on this Innovation project. It is not clear if then the 0.25 FTE County Administrative Coordinator is a part of the Evaluation budget. The County may wish to provide more details on the job duties of the County administrative coordinator and the contractor to be hired for evaluation purposes.

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 Innovation budget for this project is $3,170,514 over five (5) years. Based on the budget details provided, it appears Kern County will purchase the software and technology (which will reside on the Law Enforcement Communication Center computer system); provide funding to the Kern County Sheriff's department and Bakersfield Police Department to hire two 0.5 Lieutenants to support the implementation and training needs on the law enforcement side; the (40) forty Smart911 kiosks for the clinics; and a county staff to provide training to mental health providers helping clients and/or family members set up their profiles.

Personnel expenditures (a total of $1,737,514 over 5 years or 55% of the total budget), include the following positions:

- Two 0.5 FTE Law Enforcement Lieutenants ($945,714 over 5 years or ~54.5% of the total personnel budget) – hired by the local police and sheriff's department, to implement, maintain, and manage the Smart911 software and services, and train dispatchers and first responders.
- 1.0 FTE Kern County Program Specialist II (a total of $561,065 over 5 years or ~32.5% of the total personnel budget) to provide project management coordination and services and training and support to county staff working with clients to create the profiles on the registry.
- 0.25 FTE Administrative Coordinator (a total of $148,303 over 5 years or 8% of the total personnel budget) to provide internal program evaluation for the project.
- 0.10 FTE Senior Information Systems Specialist (a total of $74,815 over 5 years or 4% of the total personnel budget) to support the set up and maintenance of the online registration kiosks.

Operating expenditures, including one-time start-up costs, ($1,026,000 over 5 years or ~32.3% of the total Innovation budget) will include:

- $850,000 for software installation and training.
- $77,500 for internet connectivity of 40 online registration kiosks.
- $4,900 annually for incidental hardware repair or replacement.
- $49,000 for the 40 kiosks.
- $25,000 for the implementation, including marketing and start-up costs.

The project's evaluation will be contracted out and will be $223,270 over 5 years or 7% of the total Innovation budget. The County has not specified who the contractor will or how they will be selected.

The County may wish to discuss the justification of using mental health funds for this

project given majority of the budget will be diverted for law enforcement staff and a registry which will be housed on the law enforcement computer system. The County may wish to provide information on how using technological needs funds was ruled out as not a potential funding option for this project.

Innovation Program History Additional Regulatory Requirements

While this project appears to meet the minimum requirements as listed under the MHSA Innovation regulations, there are two important issues pending. The County will need to provide MHSOAC their local board approval of the plan as well as confirmation the local 30-day public comment has been completed and how any recommendations from the public comment were addressed.

References

"Responding to Persons Affected by Mental Illness or in Crisis: Evolving Methods and Standards for Law Enforcement," Accessed February 6, 2017. Presentation material International Association of Chief of Police.

"Smart 911." Elk Grove Police Department. Accessed February 6, 2017. http://www:elkgrovepd.org/community/community_programs/smart_911

"Smart9111 being adopted by growing number of communities" USA today Accessed on February 6, 2017. http://usatoday30.usatoday.com/nation/story/2012-07-12/smart 911-database/56285514/1

"Sheriff Dart to Keynote CIT International, Announces Mental Health Dispatcher Training and Investment in Smart911 Technology" Accessed February 6, 2017 https://safety.smart911.com/cook-county-il-smart911/

Kern County Innovation Project
Special Needs Registry – Smart 911

About Kern County:

Kern County is located on the southern edge of the San Joaquin Valley. With 8,163 square miles of mountains, desert and the ag-yielding valley, Kern County is geographically the third largest county in California. Bordered by eight counties, Kern lays neighbor to Kings, Tulare, Inyo, Ventura, San Bernardino, Los Angeles, Santa Barbara and San Luis Obispo. Kern County is a thoroughfare for travelers and commuters as it connects many on the north-south route via Interstate-5 and Highway 99.

Kern County has approximately 886,507 residents, the 11th highest populated county in California. Bakersfield, the county seat, has 373,640 residents and is the 10th largest city in the state. The population is made up of 51.5 percent Hispanic/Latino, 36 percent non-Hispanic White, 4.9 percent African American/Black, 4.4 percent Asian and the remainder multi-racial, Native American and Native Hawaiian or Pacific Islander. The two threshold languages are English and Spanish. Local economy is richly laden in petroleum, animal and crop-based agriculture and military-based industry.

Primary problem to be addressed:

Often, individuals experiencing a mental health emergency come to the attention of law enforcement or emergency medical service responders following a call to 911. First response staff are typically provided only that information which can be gathered over the phone by the dispatcher. During those crises, those experiencing a mental health emergency may not be able to fully articulate symptoms and other pertinent information. The lack of information about mental health conditions, supports and effective interventions contribute to decisions to use force, arrest, incarcerate or hospitalize rather than de-escalate and redirect to sustained outpatient mental health care. This leads to costly arrests, hospitalizations and sometimes, injuries to the mentally ill person and/or first responders. By creating a special needs registry, emergency responders can be privy to vital information regarding mental health symptoms, interventions, medications and plans as they arrive in order to provide more appropriate services.

Community Planning Process

Individuals from special interest groups, such as groups of individuals with behavioral health challenges as well as those with co-occurring behavioral health and developmental disability challenges, expressed interest in having a Special Needs Registry for Kern. Some of them expressed their interest to individuals who participate in the Kern Crisis Intervention Team. In turn, the he Special Needs Registry – Smart 911 project was initially proposed at the Crisis Intervention Training Steering Committee Meeting in 2014. The Steering Committee, comprised of law enforcement, Kern County Superintendent of Schools staff, members from faith-based

ministries, United Way Homeless Collaborative members, mental health professionals, community-based organizations, members from NAMI Kern and community members; recommended the registry in order to improve the quality of first responder services to achieve better immediate and long-term outcomes.

A second stakeholder group composed of persons with lived experience, family members and mental health professionals evaluated this and other proposals in order to identify proposals that best fit the Innovative program principles. The Special Needs Registry project was identified as a program that promoted interagency collaboration related to mental health services, supports or outcomes which introduced a new application to the mental health system of a promising community-driven approach that has been successful in a non-mental health context or setting. The project was selected to advance into the 2016 Community Planning Process that ultimately involved more than 325 persons throughout Kern County. Stakeholders overwhelmingly supported the project, noting that Smart 911 could reduce trauma associated with being served by police. Along with two other Innovation proposals, the Special Needs Registry was included in the MHSA Annual Update FY 16/17 where it garnered additional consideration and support during the 30-day annual review period, public hearing conducted by the Kern County Behavioral Health Board and the Kern County Board of Supervisors in November and December 2016, respectively.

Project Description

Rave Mobile Safety, Inc. has created Smart 911, a program which allows web-users the ability to create a password protected special needs registry free of charge to the user. The registry itself is accessed via Smart911.com. During calls to 911 from registered users, public safety entities that purchase and install the Smart 911 software are able to view the user-provided information on demand for a period of 45 minutes, allowing dispatchers and first responders access to critical information while also protecting the privacy of that information.

Kern County residents, including KernBHRS clients, will have the opportunity to create a secure, password-protected special needs registry on the Smart 911 website. KernBHRS clients will be encouraged to register and will be offered assistance from treatment staff. Registration will be available on personal devices (computer, tablet, smart phone) and in kiosks to be placed at each KernBHRS treatment location. Information entered into the Smart 911 database is only accessible to an emergency dispatcher and only when a registered user dials 911 from a phone number in the user's Smart911 profile. Clients may enter details which include mental health conditions, medications, medical needs and mobility issues, crisis interventions from their WRAP or Crisis Treatment Plan and other information which can assist in the event of a mental health or non-mental health related emergency. As part of the project, emergency dispatch centers throughout Kern County will be provided Smart 911 software, allowing them to receive registry information when a call is placed.

Because the registry is created by the client, only information which is shared voluntarily is released. The client creates their own profile username and password, and may manage their online account at will. With assistance from their KernBHRS Recovery Specialist, they may choose to include information from Crisis or WRAP plans; but KernBHRS will not provide information to Smart 911 or emergency dispatch centers as a result of the Innovative program. Emergency responders will, however, have the ability to share vital

information when providing emergency service, allowing for better interagency collaboration between fire, police and other public safety entities.

Innovative Component

Smart 911 has been implemented in cities throughout the United States, but Rave Mobile Safety, Inc. reports that a county has never-before implemented the program within a behavioral health system of care with the purpose of assisting clients in identifying special needs.

Learning Goals and Evaluative Measures

The Special Needs Registry – Smart 911 project will attempt to learn how Smart 911 affects the outcome of emergency services provided to those who create an online registry. It is anticipated that there will be:

- A reduction in injury, death, arrest and hospitalization resulting from emergency response to a behavioral health emergency event.
- A high rate of registration with a goal of 70 percent of new clients opting to create a special needs registry profile.
- High satisfaction rate of 75 percent or more positive feedback from clients on the effectiveness of response when public safety has access to Smart 911 information.
- Use of Smart 911 information for at least 20 percent of 911 calls which involve behavioral health key words. The first year would serve as a baseline by which to judge growth.

During services, clients will be asked if they have experienced a recent emergency event. Those who respond in the affirmative will be asked to complete a satisfaction survey via the onsite kiosk. Additionally, public safety agencies will survey dispatch and response staff felt in order to gather information about the value of their use of Smart 911 information.

Budget

The budget total for five (5) years is = $3,170,514

Personnel:

1 FTE Program Specialist = $561,065 over five years
The Program Specialist will be responsible for coordinating and providing training and support to Recovery Specialist staff working with clients to create user profiles in Smart911. This staff will also provide project management services for the implementation of Smart 911 at emergency dispatch centers, including the coordination of site trainings for dispatch staff and first response staff throughout Kern County.

0.25 FTE Administrative Coordinator (Program Evaluation) = $148,303 over five years

The Administrative Coordinator will provide evaluation of the project, gathering and analyzing surveys from emergency dispatch and responder staff, data from Rave Mobile Safety, Inc., client surveys and number of clients registered.

0.10 FTE Senior Information System Specialist = $74,815 over five years, with additional costs of $5,985 in year one for kiosk programming and installation. In succeeding years, IT staff will install and manage online kiosks at clinic sites. This is an existing position from which 10 percent of salary will be supported by Innovation funds and the remainder to be funded by its current source.

0.10 FTE Maintenance Worker II = $1,632 in year one for online kiosk installation.

2-0.5 FTE Law Enforcement Lieutenants assigned to dispatch centers = $945,714 over five years
The Kern County Sheriff's Department and Bakersfield Police Department provide law enforcement services to most of the county's population. To assume a task as involved as managing the information received from Smart 911 – supported calls, we have assigned funding for two half-time lieutenants, one at each department. These lieutenants will manage the installation of Smart 911 by Rave Mobile Safety, Inc., train dispatchers and first responders as part of ongoing implementation of the program over time and provide support for the project by administering surveys and collecting data regarding calls. Officers assigned from these two agencies may also provide support for other entities including fire department and rural law enforcement agencies.

Evaluation:

Evaluation is budgeted at $48,574 in year one, $43,574 in succeeding years, totaling $223,270 for the five-year term of the project. This cost includes both contracted and in-house evaluation services. Contracted evaluators will be provided information from KernBHRS, Rave Mobile Safety, Inc. and public safety agencies.

Operating Expenditures:

$850,000 to fund Smart 911 software, installation and training for 13 dispatch centers
$77,500 to fund connectivity for 40 online kiosks to be utilized in behavioral health clinics
$4,900 annually for incidental hardware repair or replacement

Non-recurring Costs:

$49,000 Online kiosks for behavioral health clinics
$25,000 Deployment and implementation costs

Administrative Costs:

Kern Behavioral Health and Recovery Services estimates Administrative costs at 29.4 percent of personnel costs annually. Total Administration over five years totals $422,774.

AGENDA ITEM 9

Information

April 27, 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: Motions summary from the March 23, 2017 Commission meeting; Evaluation Dashboard; Calendar of Commission activities; and Innovation Review Outline.

Handout: None

Recommended Action: Information item only

Mental Health Services Oversight & Accountability Commission

Motions Summary

Commission Meeting
March 23, 2017

Motion #: 1
Date: March 23, 2017
Time: 9:12 am

Text of Motion:

The Commission approves the February 23, 2017 Meeting Minutes.

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

Motion carried **7** yes, **0** no, and **5** 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 Lynch	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

Motion #: 2
Date: March 23, 2017
Time: 3:48 pm

Text of Motion:

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

Name: Continuum of Care for Veterans and Military Families
Amount: $3,083,777
Project Length: Five (5) Years

Commissioner making motion: Commissioner Gordon
Commissioner seconding motion: Commissioner Aslami-Tamplen

Motion carried **8** yes, **2** 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 Lynch	☒	☐	☐
12. Commissioner Mitchell	☐	☒	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 3
Date: March 23, 2017
Time: 4:25 pm

Text of Motion:

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

> Name: The Mixteco Project: Healing the Soul
> Amount: $838,985
> Project Length: Four (4) Years

Commissioner making motion: Commissioner Aslami-Tamplen
Commissioner seconding motion: Commissioner Wooton

Motion carried **10** 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 Lynch	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 4
Date: March 23, 2017
Time: 4:55 pm

Text of Motion:

For each of the 6 RFPs, the Commission:

- Authorizes the Executive Director to issue a “Notice of Intent to Award Contract” to the proposer receiving the highest overall score as follows.
  - *16MHSOAC029 for Clients/Consumers: Mental Health America (MHA) of Northern California*
  - *16MHSOAC030 for Diverse Racial/Ethnic Communities: National Alliance on Mental Illness California (NAMI California)*
  - *16MHSOAC031 for Families of Clients/Consumers: NAMI California*
  - *16MHSOAC032 for LGBTQ: Health Association Foundation*
  - *16MHSOAC033 for Parents/Caregivers of Children and Youth: United Parents*
  - *16MHSOAC034 for Veterans: California Association of Veteran Service Agencies (CAVSA)*
- Establishes March 30, 2017 as the deadline for unsuccessful bidders to file an “Intent to Protest” consistent with the five working day standard set forth in the Request for Proposals.
- Directs the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.
- Authorizes the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Ashbeck

Motion carried **10** 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 Lynch	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC Evaluation Dashboard March 2017
(updated 4/20/17)

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 (10)**	**From Sept. 30, 2016 to June 30, 2017**	**$237,663**	**Completed 7 of 10**
6	**Fiscal Transparency Component Acceptance Support**	**October 31, 2016**	**$12,000**	**Completed**
7	**NAMI Data Augmentation—Program Addresses**	**March 24, 2017**	**$3,750**	**Completed**
8	**NAMI Data Augmentation—Program Providers**	**March 31, 2017**	**$4,895**	**Completed**
9	**NAMI Data Augmentation—Three Year Plan and Annual Update Data Element Extraction**	**April 30, 207**	**$29,480**	**Pending**
Total Contract Amount			**$462,313**	

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

MHSOAC Evaluation Dashboard March 2017
(updated 4/20/17)

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**	**Completed**
5	**Resources for Promoting Practices that Encourage Recovery Orientation and Dissemination Plan**	**January 15, 2017**	**$50,000**	**Completed**
6	**Report of Policy and Practice Recommendations for Ensuring, Maintaining, and Strengthening the Recovery Orientation of Programs and Services**	**March 30, 2017**	**$50,000**	**Under Review**
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 March 2017

(updated 4/20/17)

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**	**Completed**
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 March 2017
(updated 4/20/17)

The Regents of the University of California, University of California, Los Angeles
Assessment of System of Care for Older Adults (14MHSOAC016)
MHSOAC Staff: Fred Molitor **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**	**Completed**
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.

MHSOAC Evaluation Dashboard March 2017
(updated 4/20/17)

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**	

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

MHSOAC Evaluation Dashboard March 2017
(updated 4/20/17)

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**	**Completed**
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.

MHSOAC Evaluation Dashboard March 2017
(updated 4/20/17)

MHSOAC
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 March 2017

(updated 4/20/17)

MHSOAC Evaluation Unit

Mental Health Services Act (MHSA) Performance Monitoring

MHSOAC Staff: Fred Molitor

Active Dates: Ongoing

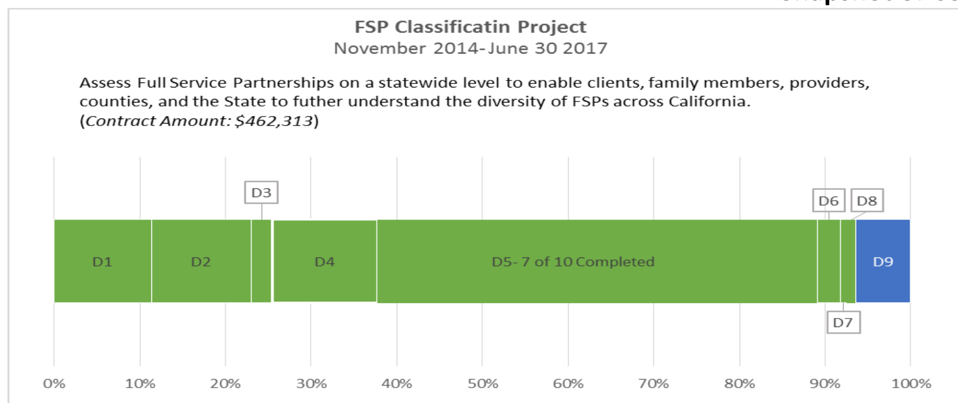
Objectives: Implement a process and system for monitoring and reporting on individual- and system-level data, including the CSI and DCR, to support characterization and assessment of MHSA programs and outcomes.

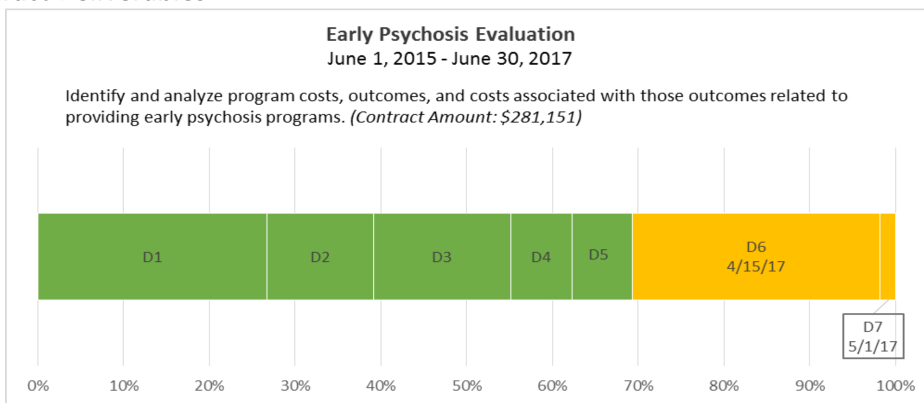
This internal evaluation project is in transition to an external evaluation project.

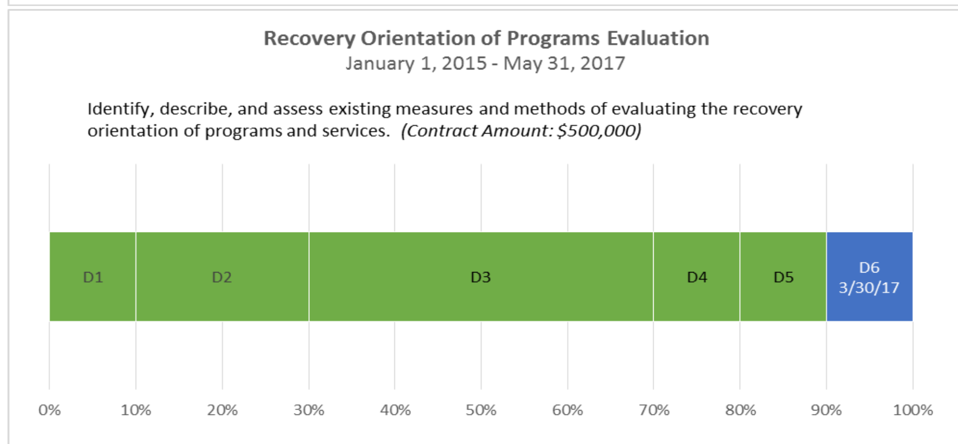
	Work Effort or Product	Due Date	Status
1	**Develop Process For Adding Additional Client, System, And Community-Level Indicators**	**December 31, 2014**	**Completed**
2	**Secure Health Insurance Portability And Accountability Act (HIPAA) Compliance For MHSOAC Staff And Information Systems To Allow Secure 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**

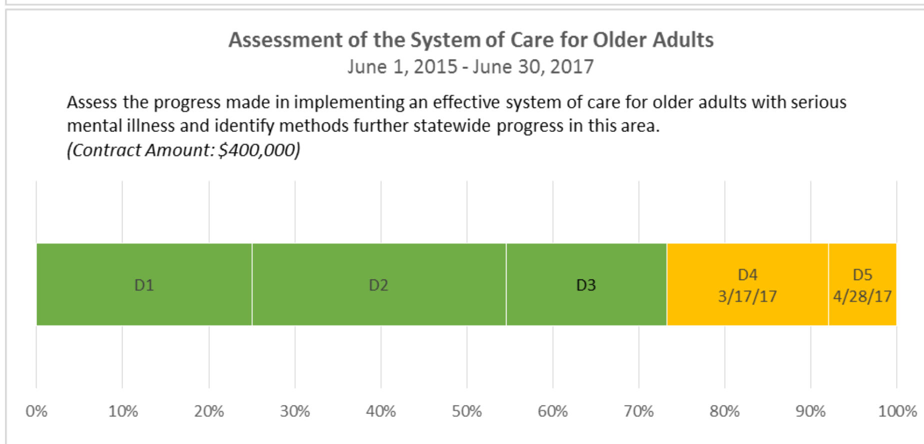
* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

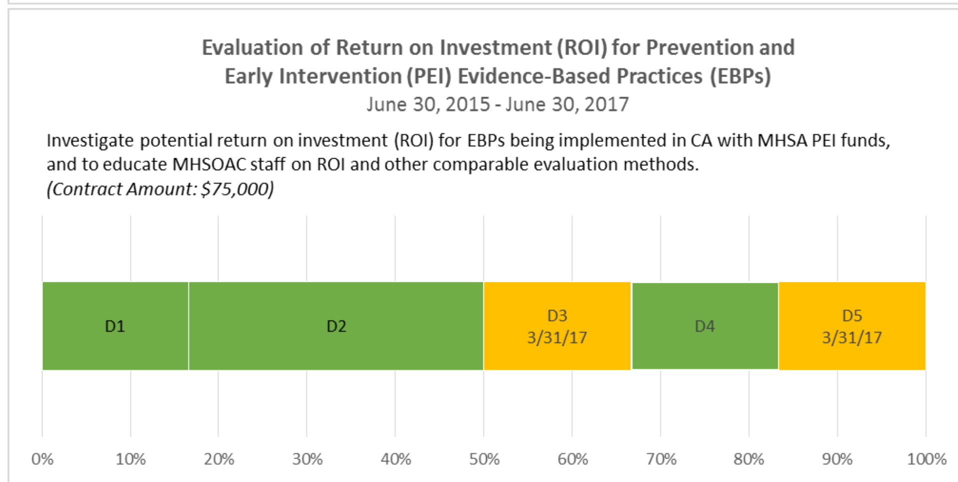
Snapshot of Contract Deliverables

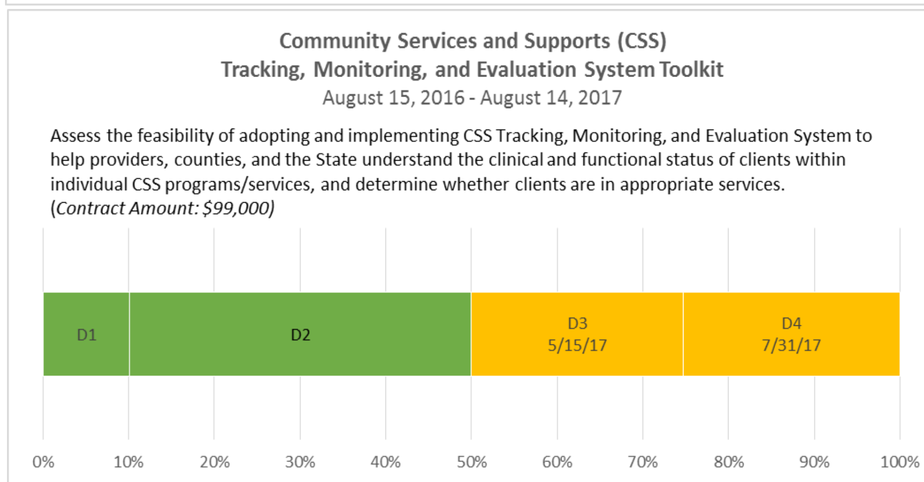












Legend: Deliverable Complete | Deliverable Pending | Deliverable Under Review

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