Commission Packet

Commission Meeting
May 25, 2017

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

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

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

May 25, 2017
9:00 A.M. – 4:00 P.M.
MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814
Call-in Number: 866-817-6550; Code: 3190377

Public Notice

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

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

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

Tina Wooton Chair	AGENDA May 25, 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**

9:20 AM **Action**

1: Approve April 27, 2017, MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the April 27, 2017 MHSOAC meeting.

- Public Comment
- Vote

9:25 AM **Information**

2: Governor's May Budget Revise Update

Presenters: Kris Cook and Jessica Sankus, Department of Finance
Brian Sala, Ph.D., Deputy Director for Evaluation and Program Operations

The Commission will be presented with information regarding the impact of the Governor's May Revision on the Mental Health Services Act and community mental health.

- Public Comment

10:05 AM **Action**

3: Strategic Planning Contract

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

The Commission will consider approval of a contract for a five year Commission Strategic Planning and Implementation Project.

- Public Comment
- Vote

10:30 AM **Information**
<u>4: Innovation Subcommittee Report Out</u>
Presenters: Vice Chair John Boyd, Psy.D., Commissioner Itai Danovitch, M.D., and Consulting Psychologist Urmi Patel, Psy.D.

The Commission will be provided with a brief report out on the Innovation Subcommittee meeting which took place on May 24, 2017.

- Public Comment

11:00 AM **Action**
<u>5: Amador County Innovation Plans</u>
Presenters: Stephanie Hess, MHSA Programs Coordinator; Alex Abarca, LCSW, Director of Behavioral Health Services at Mariposa, Amador, Calaveras, Tuolumne (MACT) Health Board, Inc.; Kathleen Shenk, BS, Director of Strategies Center; Gregory Robinson, Ph.D., Director of Applied Research and Evaluation, Strategies Center

The Commission will consider approval of two Innovative Project Plans for Amador County.

- Public Comment
- Vote

11:50 AM **Action**
<u>6: Ventura County Innovation Plan</u>
Presenters: Kiran Sahota, MA, Mental Health Services Act Manager; Dina Olivas, LCSW, Behavioral Health Manager; Hilary Carson, MSW, MHSA Administrator, Innovations

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

- Public Comment
- Vote

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

12:30 PM **Lunch Break**

1:30 PM **Action**

7: San Diego County Innovation Plans

Presenters: Alfredo Aguirre, LCSW, Director of Behavioral Health Services of San Diego County; Piedad Garcia, Ed.D., Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (BHS); Yael Koenig, LCSW, Deputy Director for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care; Jeffrey Rowe, M.D., Supervising Psychiatrist for the Juvenile Forensics Division of the County of San Diego Behavioral Health Services

The Commission will consider approval of three Innovative Project Plans for San Diego County.

- Public Comment
- Vote

2:40 PM **Action**

8: Request for Funding for Evaluation and Transparency Portal Projects

Presenters: Brian Sala, Ph.D., Deputy Director for Evaluation and Program and Fred Molitor, Ph.D., Director of Research and Evaluation

The Commission will consider approval of contracts which will support the ongoing evaluation and transparency portal projects of the MHSOAC.

- Public comment
- Vote

3:25 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.

3:45 PM **General Public Comment**

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

4:00 PM **Adjourn**

AGENDA ITEM 1

Action

May 25, 2017 Commission Meeting

Approve April 27, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the April 27, 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: April 27, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve April 27, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the April 27, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
April 27, 2017

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

866-817-6550; Code 3190377

Members Participating:

Tina Wooton, Chair
John Boyd, PsyD, Vice Chair
Reneeta Anthony
Khatera Aslami-Tamplen
John Buck
Itai Danovitch, MD
David Gordon
Kathleen Lynch
Gladys Mitchell
Larry Poaster, PhD
Richard Van Horn

Members Absent:

Lynne Ayers Ashbeck
Senator Jim Beall
Sheriff Bill Brown
Assemblymember Tony Thurmond

Staff Present:

Toby Ewing, PhD, Executive Director
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, PhD, Deputy Director, Evaluation and Program Operations
Filomena Yeroshek, Chief Counsel
Fred Molitor, PhD, Director, Research and Evaluation
Tom Orrock, LMFT, Health Program Manager
Urmi Patel, PsyD, Consulting Psychologist

[Note: Several items on the agenda were taken out of order. These minutes reflect the agenda items as taken in chronological order and not as listed on the printed agenda.]

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:18 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Chair Wooton gave the announcements and reviewed the meeting protocols.

ACTION

1: Approve March 23, 2017, MHSOAC Meeting Minutes

Action: Vice Chair Boyd made a motion, seconded by Commissioner Buck, that:

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

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Commissioner Poaster.

ACTION

4: Assembly Bill 1315 (Mullin)

Presenter: Anna Hasselblad, Steinberg Institute

Ms. Hasselblad stated AB 1315 is the Steinberg Institute’s top priority and has the potential to be a game-changer for mental health in the state of California. She stated the purpose of AB 1315 is to greatly expand resources for early detection of psychosis and other symptoms of serious mental illness and to respond with evidence-based intervention and treatments that help stem conditions before they become disabling. She summarized the key components, statistics, and strategies outlined in AB 1315.

Commissioner Questions and Discussion

Vice Chair Boyd thanked Assemblymember Mullin and the Steinberg Institute for recognizing the value of the MHSOAC in ensuring oversight stays rooted within the Commission to help bridge the public and private sectors and support the counties.

Commissioner Aslami-Tamplen asked how the bill creates new resources for counties and if it uses local county Prevention and Early Intervention (PEI) and Innovation (INN) funds or state funds. Ms. Hasselblad stated the new resources are due in large part to private commitment, which is still in development. She stated the Commission has taken a leadership role in establishing those relationships and the Steinberg Institute is working on the venue to capture those funds at the state level to allocate to the counties.

Action: Vice Chair Boyd made a motion, seconded by Commissioner Van Horn, that:

The Commission supports Assembly Bill 1315.

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

ACTION

3: <u>Assembly Bill 254 (Thurmond)</u>

Presenter: Michael Lucien, Legislative Director, Assemblymember Thurmond's Office

Michael Lucien, Legislative Director, Assemblymember Thurmond's Office, stated AB 254 will create comprehensive school-based physical and mental health services for students. The bill establishes a pilot program that will target school districts not fully participating in the existing Local Education Agencies (LEAs) Billing Option Program. There are changes to federal programs that allow school districts to receive reimbursements for direct care services, including mental health assessments and treatments. Proposed changes to the Department of Health Care Services (DHCS) will allow school districts to increase the number of providers and services and remove the cap on the number of students who receive mental health services. Funds from this bill can be used to provide direct health care services on the school site or to contract with school-based health centers.

Commissioner Questions and Discussion

Commissioner Van Horn stated this issue is critically important. Many young children have difficulties that are not dealt with. Yesterday's school site visit was an example of this type of program.

Commissioner Danovitch stated Proposition 64 establishes school assistance programs that sound much like the program described in AB 254. Mr. Lucien stated Proposition 64 funds have not been explored but every available funding source must be found for the critical needs of students.

Vice Chair Boyd highlighted Commissioner Gordon's commitment to this effort. He thanked him for bringing this issue to the Commission's attention.

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

The Commission supports Assembly Bill 254.

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

ACTION

2A: Senate Bill 191 (Beall)

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

Carla Saporta, Legislative Consultant, Senator Beall's Office, stated a 2015 state audit found that students are not being served under current school mental health services. 7.5 percent of all school-aged children in California have a serious behavioral health disorder, yet only 120,000 of those 700,000 students receive therapy or counseling as part of their Individualized Education Plan (IEP). The audit also found that LEAs and counties could benefit financially and improve access to mental health and substance use services by collaborating to provide behavioral health services to eligible students, yet these partnerships are rarely implemented. SB 191 creates demonstration partnerships between school districts, LEAs, and county mental health plans to provide universal mental health and substance use support, assessments, and services. Ms. Saporta summarized the key components and strategies outlined in SB 191.

Commissioner Questions and Discussion

Commissioner Van Horn asked how SB 191 relates to AB 254. Ms. Saporta stated they are similar, but tackle the issue differently. SB 191 creates partnerships and AB 254 creates a pilot program.

Commissioner Aslami-Tamplen asked if resources come from private partnerships or from county Mental Health Services Act (MHSA) funds. Ms. Saporta stated the fiscal aspects of this bill are still in discussion, including resources from the private sector. Counties may use many different types of funds including MHSA funds to participate in these partnerships if they choose.

Commissioner Poaster asked if mental health services will be identified through the IEP process. Ms. Saporta stated this bill will serve students that may not qualify for an IEP.

Commissioner Danovitch stated it would be helpful to learn how the integrated approaches are coordinated to address problems. Commissioner Van Horn suggested that, between now and moving to the opposite house, Senator Beall and Assemblymember Thurmond's offices get together to think through the issues of pilots versus the issues of bringing it to scale. Both sides of the house need to be of one mind when this comes to final implementation. Ms. Saporta stated she is in contact with Assemblymember Thurmond's office and assured the Commission that Commissioners Beall and Thurmond will continue to collaborate.

Chair Wooton recommended changing the term "patients" in item 17 on page 4 to individuals, consumers, or family members. Individuals who are in recovery are no longer patients.

Vice Chair Boyd asked staff to prepare a tool that shows where bills intersect, where they do not, and how they impact and influence each other so Commission decisions are not made in isolation.

Commissioner Mitchell stated that as a parent she is grateful that the Legislature is paying attention to the needs of children and is totally supportive.

Public Comment

Brandy Baggett, Family Advocate, Mental Health America of Northern California, (NorCal MHA), spoke in support of SB 191, but commented on the language in the following sections:

- Section 1, line 4 – genetics plays as much a part as historical trauma
- Page 4, line 20 – social/emotional evaluation should be included in academic/behavioral evaluations
- Page 5 – a family advocate should be included in the collaboration between social workers and county officials inside the school system

Commissioner Van Horn asked if Ms. Baggett had contacted the author's office on these issues. Ms. Baggett stated her supervisor is currently speaking with others on the inclusion of family advocates at schools.

Poshi Walker, LGBTQ Program Director, NorCal MHA, referred to the phrase "with parental consent" at the bottom of the first paragraph on page 2. NorCal MHA co-sponsored the Minor Mental Health Consent Act, which allows children from 12 to 17 to get mental health services without parental consent when a licensed clinician deems that it would be harmful for their parents to know that they were seeking mental health services. She stated this is especially true for LGBTQ and immigrant children. She encouraged the authors of SB 191 to remove "with parental consent," especially in light of the Minor Mental Health Consent Act.

Ms. Walker referred to a cross-out on page 4, line 17, about a bullying prevention program. If that program was crossed out because it did not work, finding one that does should be a high priority, as bullying and harassment create a number of negative mental health outcomes.

Anna Hasselblad, Steinberg Institute, spoke in support of SB 191. She stated school is an access point, especially when students are showing signs and symptoms of mental health issues, and is a way to capture these individuals as early as possible. SB 191 will help establish a culture of prevention and early intervention and improve coordinated care.

Action: Vice Chair Boyd made a motion, seconded by Commissioner Van Horn, that:

The Commission supports Senate Bill 191.

Motion carried 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Commissioner Poaster.

ACTION

6: MHSA Fiscal Reversion Report

Presenters: Brian Sala, Ph.D., Deputy Director, and Commissioner John Buck

Commissioner Buck, Chair of the Reversion Subcommittee, stated that the Subcommittee heard testimony on the issue of reversion. The notion in the Act is if there are unspent dollars after a certain period of time, those dollars revert back to the fund to be redistributed to the counties. But the policy outlining the process for reversion was never developed. Counties had no procedure on how to send the unspent dollars back to the state fund. The forms that were used for reporting changed a number of times and there was a tremendous amount of confusion on everyone's part, which caused a stagnation around the issue. The Reversion Subcommittee researched the issue and, with stakeholder input, created a draft report.

Deputy Director Sala provided an overview, accompanied by a slide presentation, of the key challenges, findings, and recommendations contained in the MHSA Fiscal Reversion Policy Report. He stated the reasons for establishing an MHSA Reversion Fund are to improve transparency, further incentivize counties to spend their funds in a timely manner, and create an opportunity for the state to direct expenditures of reverted funds to meet unmet mental health needs identified at the state level.

Commissioner Questions

Commissioner Van Horn referred to Recommendation 2 and stated a three-year target is difficult to meet since it takes approximately a year to get things moving because of the slow contracting process and a year to evaluate the program. He suggested extending the spending period to five years for all counties. He also suggested extending the spending period for INN projects to five years.

Commissioner Poaster stated the report indicates there has not been any reversion since 2008. He asked how funds were reverted prior to that if there was no policy in place. Deputy Director Sala stated funds were reverted in that earlier period according to the Department of Mental Health (DMH) records. The law states that three-year funds were to be spent within three years. The original policy with the DMH was that the reversion clock began upon state approval of release of the planning estimates and instructions to the counties. The funds were not released to the counties until state approval of the county plan, which could be sometime later than the start of the clock.

Vice Chair Boyd asked about community services and supports (CSS) and PEI funds. Deputy Director Sala stated CSS and PEI funds have been identified that may have been subject to reversion throughout the period of the study. The information is taken from the annual Revenue and Expenditure Reports (RER) submitted to the state by the counties.

- In the 2012-13 reporting year, there were $585,000 in CSS funds that were more than three years old
- In the 2013-14 reporting period, there were $3.9 million in CSS funds that were more than three years old, along with the $585,000 that were now more than four years old

- In the 2012-13 reporting year, there were $1.8 million in PEI funds that were more than three years old and an additional $368,000 that were more than four years old
- In the 2013-14 reporting period, there were $2.3 million in PEI funds that were more than three years old, along with the $2.2 million that were now more than four years old

Commissioner Mitchell asked for reasons given during the stakeholder process for why counties had funding left over at the end of the year and why the funding was not used for programs and interventions to help the mental health community. She stated there is no accountability for the counties because counties keep asking for more funding but have not spent the funding they were already given.

Deputy Director Sala stated there are unspent funds across all counties; some counties are more diligent than others to spend their funds. Some counties reported that they have been instructed by their auditor/controllers that they are not allowed to spend those funds because of the concern that the state would eventually require the funds to be reverted. Many counties are between a rock and a hard place on this issue.

Commissioner Lynch stated this was a voter initiative and the Constitution limits what the Legislature can do. She stated the need to present to the Legislature how the proposed policy is consistent with the initiative.

Commissioner Gordon asked about the position of the DHCS on the proposed policy.

Deputy Director Sala stated there were extensive staff exchanges during the prior draft of this report. The DHCS has a different methodology for calculating funds subject to reversion and uses the first in revenue, first out expenditures, and recognizes constraints under DMH Information Notices. The Reversion Policy Report was based entirely on county reports so there will be discrepancies between the DHCS internal calculations and the public information. Staff will continue to collaborate with the DHCS on how best to communicate what is at risk of reversion and how best to report that information.

Chair Wooton asked for additional detail on the timing. Deputy Director Sala stated the funds were originally distributed quarterly based on planning estimates issued by the DMH. Counties were required to submit county plans, based on instructions issued by the DMH, in order to receive funds. A different distribution model replaced that system wherein counties received 75 percent of their planned amount upon approval of their plan and 25 percent was reserved against completion of certain reporting requirements – the biannual Cash Flow Statement and the annual Revenue and Expenditure Report (RER). There was a fiscal spur to the counties to complete those reports. The reversion clock began at the point at which both the planning estimates and the instructions were issued. With the removal in AB 100 of state approval of county plans, it is less clear when the clock should start, since funds are now distributed on a monthly basis rather than in a lump sum.

Chair Wooton suggested the reversion dollars go back to INN because the core of the MHSA is to change how services are delivered.

Chair Wooton invited Brenda Grealish, Assistant Deputy Director, Mental Health Substance Use Disorder Services (MHSUDS), DHCS, to provide feedback from the DHCS.

Brenda Grealish thanked the Commission for collaborating with the DHCS in the reversion policy process. She summarized the takeaways from the process:

- Counties were not submitting the RER reports to the DHCS because of certain types of audits or difficulties in filling out the forms. The DHCS has been responsive and has addressed those issues.
- Counties did not know what to do with reversion or how to handle reversion. The DHCS draft MHSA Fiscal Regulations, which are expected to be out next year, will clarify the process. She stated one piece that is still unclear is about creating the Reversion Fund.
- A good lesson learned was that the PEI and INN funds were not being spent. CSS funds do not seem to have any problems – counties can clearly spend those funds. Further discussion is required for the PEI and INN funds because there is something about the setup that is not working.

Commissioner Lynch asked when the legislative package is expected to go out. Ms. Grealish stated they are targeted to go out in later spring or early summer for the official comment period. She stated a small focused stakeholder group will review the next iteration before going out to the larger stakeholder group.

Commissioner Lynch asked if the DHCS followed the statutory language of reverting after three years. There are recommendations in the Reversion Policy Report that counties hold onto the funds and not follow the statute. Ms. Grealish stated the DHCS MHSA Fiscal Regulations are consistent with statute.

Public Comment

Jan McGourty, Mendocino County Behavioral Health Advisory Board (BHAB) and National Alliance on Mental Illness (NAMI), stated her county's INN funds are directly jeopardized. The INN funds are the only funds that require individual approval. It is difficult for small counties to do innovations that have never been done before. She stated rural counties are always at a disadvantage with mental health work because of the lack of qualified staff and limited funding. Reverting any funds from small counties is inconsiderate of their circumstances.

Ms. Barlow suggested shorter-term solutions along with the regulations to prove to the counties that the issue is being tackled, such as an amendment to the county contract, an updated Information Notice, or administrative directive. She stated she will submit her full comments in writing to staff.

Karen Stockton, Ph.D., Health Services Director, Modoc County, stated it would help to remind the Commission that the MHSA plans and expenditure funds are only a small part of what counties do. The reversion timeline is not actually three years but is more like two years plus. The regulations do not include the cumbersome process to get a plan out and to recruit or retain staff. Counties are not opposed to reversion but the intent is to make the funding and services available. She stated counties want to be fair and equitable to

distribute these funds and use them in effective ways. She suggested including IT, WET, and PEI funds.

Amanda Wallner, Director, California LGBT Health and Human Services Network, echoed Commissioner Mitchell's concerns that there is funding in counties that is not being spent. She stated the need to ensure these funds are spent down, moving forward, in the way that the MHSA intended; they should be spent as part of the public process with accountability.

Susan Gallagher, Executive Director, NorCal MHA, stated she was struck by one of the findings on page 10 that the Commission has been unable to fully document the amount of unspent MHSA funds held by the counties because the state has yet to receive all required reports, and also that the Commission has been unable to document the reasons the counties have not fully spent their MHSA funds. She stated the importance of learning why the funds have not been spent before extending the time to five years.

Elizabeth Oseguera, Senior Policy Analyst, California Primary Care Association (CPCA), stated PEI and INN funds should be leveraged outside the county system with community health centers and other community partners to ensure that all resources that are already in existence are being used. She suggested that funds reverted back to the state go back into INN and PEI because that is where the MHSA intended them to be.

Commissioner Discussion

Commissioner Poaster stated it is important to look at the context that 1.9 percent of the funding is at risk of reversion, which, in a global perspective, is not a bad figure. The change in reversion came when the state was approving all programs. At that time, there was $2.5 billion sitting in the General Fund waiting to go out for services, but the process was difficult, so the Legislature moved $682 million out of the MHSA fund. He stated no funds should be reverted. INN is the only program it now affects because there is still an approval process with funding being distributed on a monthly basis by the Controller for INN. The funding cannot be spent until the program is approved, which means the reversion clocks begin well before the Commission gives their approval. Reversion is in the MHSA as an incentive to spend the funding.

Commissioner Poaster stated he could support the recommendation to establish an MHSA Reversion Fund if those funds were used to bolster INN work. He stated the concern that funds may not be used for INN.

Executive Director Ewing suggested amending the last recommendation to include that that the Reversion Fund preserve the original component of the reverted funds.

Chair Wooton asked Commissioner Buck, the Chair of the Subcommittee, how he would like to proceed. Commissioner Buck stated there will never be a proposal that all individuals fully embrace. The most commendable thing to do is to move this forward so that there eventually will be resolution and the public can say action was taken.

Action: Commissioner Buck made a motion, seconded by Vice Chair Boyd, that:

The MHSOAC adopts the report: Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities, with a change to Recommendation 4 to preserve the reverted funds to the MHSA components from which those funds came from.

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

ACTION

2B: Senate Bill 192 (Beall)

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

Ms. Saporta summarized the key components and strategies outlined in SB 192 and asked for the Commission's support.

Public Comment

Ms. Hasselblad stated the Steinberg Institute is co-sponsor of SB 192. She spoke in support of the bill.

Kirsten Barlow, Executive Director, County Behavioral Health Directors Association (CBHDA), stated the CBHDA has shared its concerns with the author's office and is hopeful to take a support if amended position. She highlighted overlapping content in the bill and the Commission's reversion policy report. Counties feel it is important to note that consumers and family members are at the table. A state-level fund silences the voices at the local level.

Heidi Strunk, Advocacy Coordinator, California Association of Mental Health Peer-Run Organizations (CAMHPRO), echoed Ms. Barlow's comments and stated SB 192 is not the solution to the problem as it is written because it overlooks a valuable component to the MHSA – the stakeholder process. She requested that the Commission refrain from supporting SB 192 as it is currently written.

Sally Zinman, Executive Director, CAMHPRO, agreed with the previous speakers. She stated unspent funds mean unmet needs. She stated her concerns that the bill diminishes the stakeholder process on the local level and directs funds toward specific populations.

Ms. Saporta stated the bill does not circumvent the community process nor is it the intent of the Legislature to undermine the value of community process. Also, the bill states the funds should go to Prevention and Early Intervention (PEI) and Innovation (INN) programs and lists priorities; however, that language is permissive and is listed as examples of where funds could be used.

Commissioner Questions and Discussion

Commissioner Aslami-Tamplen suggested that the bill specifically state the inclusion of local stakeholders in the process. Ms. Saporta stated she would take this suggestion back to the author.

Action: Commissioner Anthony made a motion, seconded by Vice Chair Boyd, that:

The Commission supports Senate Bill 192.

Motion carried 10 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

The following Commissioner voted "No": Commissioner Lynch.

GENERAL PUBLIC COMMENT

Lisa Pion-Berlin, Ph.D., President and Chief Executive Officer, Parents Anonymous, urged the Commission to take charge of the protest process on the stakeholder grants and to commit to a fair and open process.

Michelle Allen, Parents Anonymous, stated concern that the organization that was awarded the grant is not made up of parents. The grant is going to an organization of lawyers and advocates and not parents as it should.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated she sent letters to the Commissioners with concerns and wants answers to those concerns. She stated the concern that the same organization was awarded two contracts. The proposals from the same organization for different populations should have been reviewed side-by-side. The work plans are the same for both proposals and does not elaborate upon proposed activities. She also questioned if the organization could bill twice for the same activity.

Tando Goduka, Executive Administrative Manager, CAMHPRO, stated concern that the contract was awarded to an organization that is not run by peers. A culture of modeling consumer values is important for representing the consumer voice.

Mary Hogden, Pool of Consumer Champions (POCC), urged the Commission to continue to support CAMHPRO.

Ms. Wallner announced the May 16th LGBT advocacy day at the State Capitol. She encouraged the Commission to take a stand on federal level activities that will impact mental health care delivery in the state.

Paulette Franklin, POCC, stated CAMHPRO has developed a connection with the consumer community, which gives the organization the authority to speak and advocate for that community. She requested continued funding for CAMHPRO.

Janet King, Native American Health Center, stated concern that the California Pan-Ethnic Health Network (CPEHN) and REMHDCO, which have a good track record, were not selected for the stakeholder advocacy contract. She also expressed concern that a rapport with and respect for marginalized communities was not adequately measured in the selection, as this is crucial for the organization that is awarded the grant.

Beatrice Lee, President, REMHDCO, stated the concern that awarding multiple contracts to one organization will not diversify target population groups.

Rebecca Gonzales, REMHDCO, questioned the qualifications and experience of reviewers of the proposals. For example, a person of color may not be culturally competent within their community.

Ms. Zinman asked for confirmation that Commissioners receive letters from CAMHPRO. Vice Chair Boyd confirmed that they received multiple letters.

Ms. Zinman stated the RFP process is not equal when measuring grassroots stakeholder organizations and is instead geared towards large organizations with funding and staff. Nothing in the proposal measured long-term community relations, even though the trust of the community is what enables an organization to have authority to advocate for them. She expressed concern that consumers' interests will not be specifically represented by the organization that were awarded the contracts.

ACTION

7: <u>Modoc County Innovation Plan</u>

County Presenter: Karen Stockton, Ph.D., M.S.W., B.S.N., Health Services Director

Dr. Stockton provided an overview, accompanied by a slide presentation, of the proposed Modoc County INN project including the budget for the project.

Commissioner Questions

Commissioner Anthony asked about the participants in the study, how inputs are proposed, and how participation is encouraged. Dr. Stockton stated there was stakeholder participation through the advisory board and the peer group from the peer-run and operated wellness center and a county peer staff member plays a liaison role. The California Institute for Behavioral Health Solutions (CIBHS) coordinator will collect the information for participants, track the shared planning, get their feedback, and work with the clinicians. This program will be implemented as part of the county's standard practice for all individuals seeking service. The buy-in for the program will come when the clinicians share dashboards with their patients and their families.

Commissioner Danovitch stated his question is less about innovation and more about feasibility, which is the aspiration to use data in analytics to drive improvement and to coordinate across multiple systems of care. He asked about the type of data that will be collected, how it will be analyzed, and how providers are expected to use the data.

Dr. Stockton stated data will be collected across basic wellness domains, evidence-based practice measures, and physical health measures cross walked with the Electronic Health Records (EHR) that will be made available real-time for individuals and their clinicians. She stated the hope to accumulate aggregate data to make statistics more meaningful. She stated this is where the field is going and, if there is not a practice management system, given payment reform, the county mental health system cannot survive. High-level PEI requires a population management system.

Commissioner Van Horn stated Innovation projects fall into four categories: a new practice, an adaptation from another discipline to the behavioral health world, a refinement of something which has community-based evidence but has yet to be verified, and a major change in administrative practices which can make the whole system run more smoothly. This Innovative project is the latter and is something he has been fighting for since 1991.

Vice Chair Boyd asked how soon the project can be implemented. Dr. Stockton stated everything is in place; she would like to begin the initial training next month.

Public Comment

Ms. Walker asked if the data being collected will include sexual orientation and gender identity data. Dr. Stockton stated the county will collect data within the current state guidelines.

Ms. Walker asked why half of the budget will go to CIBHS and why CIBHS is not providing technical assistance without charging the county extra because they already receive funding for that. Dr. Stockton stated they are not sole-sourced for this project. A large portion of this budget will go to the vendor that will develop and modify the EHR. A portion of it is for data analysis training that CIBHS does not have separate funding for and for the high-quality evaluation they will conduct.

Commissioner Discussion

Commissioner Anthony stated the importance that information gathered for the participants in the program is conveyed in a positive fashion and that there be buy-in through the entire process, because many times clients feel everything is being done to them. It is important that clients feel they have some control over their treatment and recovery.

Chair Wooton asked why some of the funding for the project did not come from the Capital Facilities and Technological Needs Fund. Dr. Stockton stated the input received from the stakeholder was to use those funds for EHRs. To spend more of it on this INN project would require stakeholders to reverse their decision about Capital Facilities.

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

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*
> *Program Length: Four (4)Years*

Motion carried 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Chair Wooton.

ACTION

8: <u>Kern County Innovation Plan</u>

County Presenters: William Walker, LMFT, Director of Kern Behavioral Health and Recovery Services, and Brad Cloud, Psy.D., Deputy Director of Kern Behavioral Health and Recovery Services

William Walker, LMFT, Director of Kern Behavioral Health and Recovery Services (KBHRS), introduced several individuals in attendance from Kern County. He deferred to Brad Cloud, Psy.D., Deputy Director, KBHRS, to give the presentation.

Dr. Cloud provided an overview, accompanied by a slide presentation, of the problem, innovative solution, and learning objectives of the Kern County INN Project. He stated Smart 911 has been used successfully, but never in a behavioral health context. Better information from an online registry will increase the safety of clients and first responders during emergencies and reduce criminalization due to mental illness and the unnecessary use of hospitalization.

Commissioner Questions and Discussion

Commissioner Anthony asked about the participants in the study, how participation is encouraged, and how the county will deal with a lack of participation. Dr. Cloud stated stakeholders are both interested in the project and have reservations about it. The motivating factor is to ensure that the most updated information is available to first responders. Progress reports will also help individuals decide if the registry is the right thing for them.

Mr. Walker stated one of the outcomes the county wants to learn about is if the fear to be a part of the program can be bridged through peers engaging peers to make their profiles. The project will be less effective if it is pushed from a management perspective.

Commissioner Buck stated the fact that individuals voluntarily input and control their own information is heartening. He asked if the project will be connected to EMTs. Dr. Cloud stated the software will be installed in all public service answering points (PSAPs) throughout the county that serve law enforcement and emergency medical responders.

Commissioner Mitchell asked about the phone number that will be used. Dr. Cloud stated multiple numbers can be used. Individuals are associated to phone numbers in their profiles, including family member numbers, with their approval.

Commissioner Aslami-Tamplen asked about parents creating profiles for teens. Dr. Cloud stated the information is intended to be entered by the individual who is the subject of the information. The phone numbers used require verification to protect against numbers fraudulently being entered into profiles.

Chair Wooton suggested changing the name of the project and not use the term “Special Needs” as a way to move away from labeling.

Commissioner Lynch asked how the profiles will be kept current. Dr. Cloud stated Smart 911 periodically prompts users to update their information through email and staff will remind clients during services to add or change information in their profiles.

Vice Chair Boyd asked about nuances of the mental health community for this already-established model and about peer engagement and employment in the project. He also stated the personnel budget seems high. Mr. Walker stated the value of the project is that it brings parties together in a non-emergency before an emergency. This is a substantial INN project for the PSAPs so staff training will consume a great deal of time, as will updating that information on a continual basis. Considerable personnel time is expected to manage the project in the 13 PSAPs, to collect and analyze data, and to participate in the study.

Chair Wooton asked about peer employment in the project. Dr. Cloud stated there are no peer positions involved in the project but peers work in most of the county clinics, serve

as navigators in the system, and will be relied upon to help individuals learn if Smart 911 is right for them.

Vice Chair Boyd stated he loved to hear that peers serve as navigators and in clinics, but projects like this are incredible opportunities to train up and staff up and bring everyone in to a broader definition of the work. This is a perfect initiative to do that.

Public Comment

Ms. Wallner stated she did not see anything about disparities in negative law enforcement interactions. There are variations based on race, ethnicity, gender identity, and sexual orientation with regard to negative law enforcement interactions. She suggested that including an evaluation measure on equity would strengthen this proposal and is essential to ensure that equity is increased in terms of law enforcement interactions. Reducing negative outcomes based on race, ethnicity, gender identity, and sexual orientation should be essential to this proposal.

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

Pending Kern County's Board of Supervisors approval, the MHSOAC approves Kern County's Innovation Project, as follows:

> *Name: Special Needs Registry Smart 911*
> *Amount: $3,170,514*
> *Program Length: Five (5) Years*

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Buck, Danovitch, Gordon, Lynch, Mitchell, and Van Horn.

ACTION

5: Technical Assistance Contract

Presenter: Brian Sala, Ph.D., Deputy Director, and Norma Pate, Deputy Director

Deputy Directors Pate and Sala provided an overview, accompanied by a slide presentation, of the purpose, need, and benefits of entering into contracts for technical assistance.

Commissioner Questions and Discussion

Chair Wooton asked if the contract will be paid from the Commission's administrative fund. Deputy Director Sala stated the budget does not differentiate how funds are expended. A portion of the contract will be paid from the $2.5 million research and evaluation activity budget.

Chair Wooton asked about in-house accounting controls over the way the funding is used. Executive Director Ewing stated the Commission is subject to audits by the Department of Finance (DOF) and the Bureau of State Audits. In addition, the Department of General Services (DGS) manages the Commission's checkbook but not the bank account.

Commissioner Lynch asked why the Commission will contract out for training instead of getting it at no cost from the state. Deputy Director Pate stated DGS does not provide training to agencies that want to become independent from DGS services.

Action: Vice Chair Boyd made a motion, seconded by Chair Wooton, that:

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.

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Buck, Danovitch, Gordon, Lynch, Mitchell, and Van Horn.

INFORMATION

9: <u>Executive Director Report Out</u>

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

Executive Director Ewing presented his report:

<u>Personnel</u>

There are two vacant staff positions and three new positions are in the process of being approved.

<u>Stakeholder Contracts</u>

Four stakeholder contracts have been processed. Three stakeholder contracts were subject to protest. The protest period was resolved yesterday; the awards released last month were sustained. Staff will prepare written responses to all protest letters received.

<u>Project Updates</u>

- PEI and INN Regulations: The subcommittee met to discuss small counties, identified areas of concern, and is working to operationalize those concerns, such as amendments to the regulations.
- Schools and Mental Health: The site visit yesterday to a school in Richmond was a phenomenal success. The next subcommittee meeting is in June.
- Criminal Justice and Mental Health: Key themes are being identified for the report. A community forum will be held this weekend in the Bay Area.
- Issue Resolution: A draft report will be presented to the Commission in the next few months.
- Fiscal Reporting Tool: The online tool will allow the Commission to highlight funds received by county and fiscal year. Executive Director Ewing brought the tool up on a screen and pointed out areas of interest.
- Children Crisis Services: Staff is working with an editor on the Children Crisis Services Report. A draft report is expected within the next couple of weeks.

<u>Triage Grants</u>

Staff is preparing another round of triage grants and working to address concerns raised in the past round, such as the evaluation process. Staff is in contact with the counties, the

Legislature, and the Department of Finance to ensure that the evaluation component is consistent with the direction given by the Legislature for the triage grants.

Mental Health Matters

Mental Health Matters Day is May 24, 2017. The Commission typically partners with a number of stakeholder organizations to provide funding to support speakers and other activities.

Legislation

The Commission is sponsoring three bills:

- AB 860, Cooley: This bill passed without opposition out of two policy committees and is now at the Fiscal Committee.
- AB 1134, Gloria: This bill passed on consent out of the Policy Committee and Appropriations and will soon move to the floor.
- AB 462 Thurmond: This bill passed out of the Assembly without opposition and is now in the Senate.

37th Annual CMHACY Conference

The 37th Annual California Mental Health Advocates for Children and Youth (CMHACY) Conference will be held at the Asilomar Conference Grounds in Pacific Grove from May 17th through 19th. Chair Wooton will be speaking on Friday as part of the Policy Panel.

Budget

Staff is working to create an annualized budget that would show the proposed spending at the beginning of the fiscal year and activity-based costing that would show the estimated cost for activities. Software consultants are helping staff set up the necessary tools. The first annualized budget will be presented to the Commission in July.

Strategic Planning

Staff is working to identify a consultant to update the Commission's strategic plan.

Commission Meeting Calendar

Executive Director Ewing proposed canceling one Commission meeting in the second half of the calendar year if it does not impact the INN plan approval process for counties.

Innovation Event, Summit, or Fest

Staff is gathering information from counties on putting together an Innovation Summit. The next step is to put together a design proposal for the event.

Commissioner Questions and Discussion

Vice Chair Boyd suggested supporting Workplace Mental Health to ensure psychological safety in the workplace and build social connectivity to allow the workplace to enhance everyone's emotional mental health wellbeing. It is an opportunity for the Commission to step up and lead on this front. He suggested writing a White Paper on workplaces in California, designing an approach, and becoming more involved with statewide and

national partners that are involved in something truly innovative in workplace mental health.

Commissioner Mitchell suggested contacting the DHCS or the CDPH for their information on workplace wellness programs currently under way.

GENERAL PUBLIC COMMENT

Ms. McGourty agreed with supporting the Workplace Mental Health initiative. She spoke against the No Place Like Home initiative, which uses MHSA funds for funding competitive grants for housing. She stated the concern that rural counties always lose in a competitive grant process. Her county needs more resources, not another competition for them. The No Place Like Home board members are from the state with urban experience in their careers or representatives of large counties. The executive director from this Commission and the one required representative from rural counties were not in attendance at the meeting she attended. She asked where the accountability was in using MHSA funds.

Ms. Walker stated concern about the tone and content of some of the public comments made today in protesting the outcomes of the stakeholder contracts. Making disparaging remarks either directly or through insinuation about the new contract holders does not help advocacy efforts and can harm the efforts of advocates by creating doubt that they are credible entities. The competitive process was meant to allow new players to come to the table and this inherently means that some of the previously sole-source organizations may not be awarded a contract through the competitive process. Whatever challenges there may have been with the process, it was still a level playing field. She thanked staff for addressing the concerns voiced during the first round and improving the process for the second round. She stated the hope that advocates will collaborate with each other going forward.

Ms. Hiramoto stated she did not hear the tone of public comment as disparaging the other awardees but as concern about the process and the outcome. She clarified that REMHDCO sent a second letter to the Commission about the rule that applicants can only protest their own score but no other part of the RFP. REMHDCO has valid concerns about other parts of the RFP which were raised early in the process but were not addressed, such as the concerns that the executive director was the final and only arbitrator during the appeal process and that one agency can be awarded more than one contract. She stated the hope that staff will respond to that second letter. She stated she was disappointed that the update on the RFP was not agendized, which kept the Commission from engaging in open dialogue.

Ms. Gallagher stated NorCal MHA is the oldest consumer-run organization in California. Previous awardees of the contract did great work. She stated the hope to move forward in the spirit of collaboration now that the competition is over.

ADJOURN

There being no further business, the meeting was adjourned at 4:00 p.m.

AGENDA ITEM 2

Information

May 25, 2017 Commission Meeting

Governor's May Revise Budget Update

Summary: Kris Cook and Jessica Sankus, Department of Finance will review the Governor's May Budget Revision and discuss its impact on the Mental Health Services Act (MHSA) and the community mental health system. The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will also hear an update on the impact on any changes to the MHSOAC's budget since the release of the Governor's Budget in January.

Brian R. Sala, Ph.D., Deputy Director of the MHSOAC, will present the May 2017 Financial Report, which has been updated with information made available through the release of the Governor's May Revision to the Fiscal Year 2017/18 Budget. This report will provide information on the following topics:

- MHSA Revenues Received
- Community Mental Health Funding Amounts: Role of Major Funding Sources
- MHSA Funding Distributed
- MHSA State Administration

Presenters: Kris Cook and Jessica Sankus, Department of Finance; Brian Sala, Ph.D., Deputy Director for Evaluation and Program Operations

Enclosures: None

Handout: The May 2017 MHSA Financial Report and a PowerPoint will be provided at the meeting.

Recommended Action: None

Motion: None

AGENDA ITEM 3

Action

May 25, 2017, Commission Meeting

Strategic Planning Contract

Summary: The Commission will consider authorizing the Executive Director to enter into one or more contracts to support the development of a MHSOAC Five-Year Strategic Plan.

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

Enclosures: None

Handouts: None

Proposed Motion: The MHSOAC authorizes the Executive Director to enter into one or more contracts for a total amount not to exceed $500,000 to assist the Commission in designing, developing and delivering a Five-Year Strategic Plan.

AGENDA ITEM 4

Information

May 25, 2017 Commission Meeting

Innovation Subcommittee Report Out

Summary: The Commission appointed five commissioners: Commissioner John Boyd (Chair), Commissioner Itai Danovitch (Vice-Chair), Commissioner Lynne Ashbeck, Commissioner Dave Gordon, and Commissioner Tina Wooton as the new Subcommittee of Innovation at the February 2017 Commission Meeting.

The presenters will provide an overview of the first Subcommittee meeting held on May 24, 2017 and next steps for future Subcommittee meetings and projects.

Presenters: Vice-Chair John Boyd, PsyD, MHA; Commissioner Itai Danovitch, MD; Urmi Patel, PsyD, Consulting Psychologist

Enclosures: None

Handouts: None

Recommended Action: Information item only

AGENDA ITEM 5

Action

May 25, 2017 Commission Meeting

Amador County Innovation Projects

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Amador County's request to fund the following new Innovative projects, for the duration of five (5) years per project and a total amount of $1,631,788 (see below for project breakdown):

(A) **Circle of Wellness: Mother, Child, Family-** $918,920

(B) **Co-Occurring Group for Teens-** $712,868

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.

- Amador County proposes using Innovation funds to provide behavioral health screening and services to pregnant and post-partum women seeking primary care/obstetric services at the Amador MACT (Mariposa, Amador, Calaveras, Tuolumne) primary care clinic. The Innovation project will be through a contract with the MACT Amador Clinic to hire a 1.0 Full Time Equivalent (FTE) clinician to provide these behavioral health screenings and services.
- Amador also proposes using Innovation funds to provide a co-occurring group for teens to address their substance abuse and mental health issues. This group will be held at a substance abuse treatment center and will be co-facilitated by 1.0 FTE substance abuse counselor and 1.0 FTE mental health clinician.

Presenter(s):

- Stephanie Hess, MHSA Programs Coordinator
- Alex Abarca, LCSW, Director of Behavioral Health at MACT Health Board, Inc.
- Kathleen Shenk, BS, Director of Strategies Center
- Gregory Robinson, PhD, Director of Applied Research and Evaluation, Strategies Center

Enclosures (5): (1) Biographies for Amador County Innovation Presenters (2) Staff Summary, Circle of Wellness: Mother, Child, Family; (3) County Project Brief, Circle of Wellness: Mother, Child, Family; (4) Staff Summary, Co-Occurring Group for Teens; (5) County Project Brief, Co-Occurring Group for Teens.

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

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/2017-05/amador-county-inn-description-circle-wellness

http://mhsoac.ca.gov/document/2017-05/amador-county-inn-description-co-occurring-group-teens

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

Name: Circle of Wellness: Mother, Child, Family
Amount: $918,920
Project Length: Five (5) Years

Name: Co-Occurring Group for Teens
Amount: $712,868
Project: Length: Five (5) Years

Biographies for Amador County Innovation Presenters

Stephanie Hess, MHSA Programs Coordinator, Amador County Behavioral Health Services (ACBHS) has been with Amador County BHS for four and a half years. For the past year and a half, she has acted as the MHSA Programs Coordinator and is responsible for the administration, planning, and development of all MHSA-related activities and programs in Amador County. Prior to her position as MHSA Coordinator, she was a Senior Finance Assistant for Amador County BHS and served as the Secretary-Treasurer for the non-profit organization, California Behavioral Health Administrator's Association.

Alex Abarca, LCSW, has served as Director of Behavioral Health Services at MACT Health Board, Inc., since July 2015. MACT is a Tribal Health Consortium offering services to Native and Non-Native Americans in the four counties we serve. He provides direct therapeutic services to our patients and am responsible for the planning, organization, implementation, and supervision of the Integrated Behavioral Health Program. Prior to coming to MACT, he served as the Director of BH at Golden Valley Health Centers in the central valley overseeing a very large BH program within one of the largest Federally Qualified Health Centers in California. As a clinic member to the California Primary Care Association, he is the current chair of the Behavioral Health Peer Network with the focus on networking and influence on the legislative process that impacts BH services offered to patients in our communities. He attained his Master's degree in Social Work in 2003 and has almost 20 years of experience in the mental health and medical field.

Kathleen Shenk, BS, Director of the Strategies Center, oversees and guides Strategies Center projects and initiatives. Kathleen's career has followed a lifelong path promoting and supporting the health and well-being of children and families, while advancing the practice of interagency cooperation and collaboration. She is a high-performing leader in nonprofit management and a program development and implementation expert. As a nonprofit executive director for more than 23 years, her organization was a two-time recipient of the Pennsylvania Governor's Award for Professional Excellence. Kathleen partners with clients to apply theory and evidence-based practices, clarify and disentangle the conceptual and practical issues in complex projects and initiatives, and implement and maintain evaluation processes in make-sense ways. Kathleen's experience and training includes, but is not limited to, Safety Organized Practice, Differential Response, Sexual Assault Response Team certification, Multi-Disciplinary Interview Center Team certification, forensic interviewing, HIPAA Compliance Officer (8 years), Structured Decision Making, administrative oversight of clinical programs for a child abuse prevention council (Child Abuse Treatment Program, Parent-Child Interaction Therapy, Cognitive-Behavioral Therapy, Multi-Systemic Treatment, art and music therapy, Functional Family Therapy, among others), trained facilitator for Family Team Meetings and Team Decision-Making Meetings, Grantsmanship Center grant writing certificate, oversight of Targeted Case Management, member of the CA State Targeted Case Management steering committee, member of Placer County's System Improvement Plan and Peer Quality Case Review teams, program evaluation, and compliance and reporting, among others.

Gregory Robinson, PhD, the Strategies Center's Director of Applied Research and Evaluation, has successfully completed over 150 evaluation, applied research, and survey projects for university, foundation, federal, state, county, municipal, and nonprofit sponsors. Greg is adept at assisting Strategies Center clients in articulating information needs, transforming these

needs to research and evaluation objectives, specifying research and evaluation designs, and selecting or developing measures appropriate to the socio-political and cultural-linguistic context of the area in which the project is developing. Greg is a skilled quantitative and qualitative analyst, producing reports in a variety of formats tailored to the information needs of multiple audiences from academics to practitioners to neighborhood residents. He had moderated over 200 focused group discussions. Using a data set of 17,800 adults and 25,400 children served by 53 federal Regional Partnership Grant (RPG) Program grantees over a 5-year period, Greg was the primary quantitative analyst preparing a report to the US Congress and federal Children's Bureau. In 2015, he prepared a similar report for 2-year extension grantees working with families including a parent or caregiver with substance abuse disorder involved with, or at risk of involvement with the child welfare system and the courts. Greg is an author of "Promising Results for Cross-System Collaborative Efforts to Meet the Needs of Families Impacted by Substance Use" (2015) Child Welfare v. 94, no. 5, pgs. 21-43. He is currently working on a contract to evaluate INN projects in a county of comparable size and completed extensive MHSA local planning processes in Mono and Ventura counties subsequent to the approval of the Mental Health Services Act in 2004.

STAFF INNOVATION SUMMARY — AMADOR COUNTY

Name of Innovative (INN) Project: Circle of Wellness: Mother, Child, Family

Total INN Funding Requested for Project: $918,920

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: November 22, 2016
County Submitted Innovation (INN) Project: December 2016
MHSOAC Consideration of INN Project: May 25, 2017

Project Introduction:

Amador County proposes using Innovation funds to provide behavioral health screening and services to pregnant and post-partum women seeking primary care/obstetric services at the Amador MACT (Mariposa, Amador, Calaveras, Tuolumne) primary care clinic. The program will hire a 1.0 FTE clinician who will be co-located at the MACT clinic located in Amador County. The County proposes to create a systematic change in an attempt to prevent or intervene early on mental health challenges at the onset of pregnancies.

In the balance of this brief we address specific criteria that the MHSOAC 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 MHSOAC 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

According to the County, approximately 283 births occur in a year, of which 2.1% (6 births) are to an American Indian/Alaska Native mother and 24.3% of the 0-5 children live in poverty. In reviewing data from kidsdata.org, Amador ranks third of the MACT counties in total number of births, below Tuolumne and Calaveras and above Mariposa. Kidsdata.org also reports Amador County had 41-53 births to a Hispanic American/Latina mother and 0-2 births to an American Indian/Alaska Native mother between 2011 and 2013. The County also states they have a higher percentage of individuals reporting depression, anxiety, and bipolar disorder than the state average. It is unclear where the County has

obtained this data; however according to the Department of Health Care Services California Mental Health Prevalence Estimates, Amador appears to be similar to the State average of 15.9 of the population needing mental health services to address less severe mental health issues.

The County also reports acknowledging the need to improve their services to the perinatal population in early 2015 when community members for various local agencies established the Amador-Calaveras Perinatal Wellness Coalition. This coalition brought about a cross-county collaboration amongst the two neighboring counties to improve the professional development, community awareness and education, and implementation of improved screening and referral systems for perinatal women living in these two counties.

Furthermore, Amador County reports three Native American (NA) tribes residing in their rural county. This led the County to collaborate with neighboring counties (Calaveras, Mariposa, and Tuolumne) to establish the Mariposa, Amador, Calaveras, and Tuolumne (MACT) Health Board, Inc., a tribal consortium providing medical, dental, and behavioral health services to American Indians and Alaska Natives (AI/AN) and non-native patients in the four counties. The Health Board has four primary care and three dental clinics located amongst the four counties. The County reports these clinics offer some behavioral health services but did not share specific information on the type of services available. The County may wish to provide more demographic information on the women seeking services at the Amador MACT Clinic. The MACT health board clinic website provided limited information on the services available and focused on primary care and dental care. This is the organization Amador County intends to contract with to implement this Innovation project.

The Response

The County is proposing to increase access to behavioral health screening and services by adding a full-time clinician to the MACT clinic located in Amador County. While the County states they have not partnered with MACT in the past in this manner, other counties have demonstrated success in establishing partnerships with local primary clinics, especially to improve outreach to underserved populations utilizing such settings for physical and often mental health needs. Furthermore, the County states MACT has an established integrated behavioral health program, so it will help to discuss why MACT cannot expand their services from funding used to support their current behavioral health system and how this plan will bring new information to the mental health system.

The County indicates the Circle of Wellness program will add the following services to the MACT clinic for all pregnant women: individual counseling sessions, outreach and education about mental health, post- partum evaluations for mental health issues, yearly mental health wellness visits for every identified child age 1-17, and parenting groups. The individual counseling sessions will be given at the initial medical appointment of the pregnant women and minimally at every trimester during pregnancy. The pregnant women will also be minimally offered a behavioral health appointment post-partum as well. The parenting groups will also be offered weekly. The County may wish to discuss

how all these services will be provided by 1.0 FTE and will include the cultural competency required when working with the Native American and Hispanic American populations this project intends to target and the largest population of individuals seeking services from MACT clinics.

The County has demonstrated conducting research to see what other counties offer similar programs, including Los Angeles County USC Medical Center and their very own Sutter Amador Hospital Women's program. While each program differs from what the County intends to offer in their innovation plan, it remains to be unclear how the County will provide better behavioral health services to perinatal women seeking primary care services at the MACT Clinic. Specifically, many best practices have come forward to address the needs of pregnant women, however, the County has not indicated if they will be using these best practices, or what new practices or adapted techniques they will be utilizing resulting in new knowledge being contributed to the mental health field.

The County states their intention is to improve interagency collaboration amongst the MACT Health Board, the Behavioral Health department, Sutter Amador Hospital Women's Center, the Amador-Calaveras Perinatal Wellness Coalition, and the Tribal public funding program. It is unclear how the innovation plan will address this interagency collaboration and the County may wish to share more details.

It appears the County seeks to target pregnant women experiencing mild to moderate mental health level symptoms through this project and continue to send those with serious and persistent mental health illness to the local behavioral health system of care. It appears the County has utilized Prevention and Early Intervention funding to improve the community education, screening and access to women presenting with mild to moderate level symptoms. The County may wish to elaborate on their current PEI programs and how expanding these services to include early intervention and best practices will not address the gaps as seen by other counties, especially given they will continue the plan if successful, through PEI funding.

The Community Planning Process

The MHSA regulations indicate stakeholder participation will be present at every step of the way for the Innovation project, 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 states the idea was proposed to the Behavioral Health department by Alex Abarca, LCSW, Director of Behavioral Health, MACT Health Board in May 2016. MACT then presented this idea to the Cultural Competency Steering Committee as part of the Community Planning Process. The County may wish to discuss how the process remained fair given the idea was generated by the organization who will receive the contract for this project should the plan be approved.

The County did ensure they solicited input from stakeholders and county staff, Native American Tribes, Hispanic populations, Veterans, TAY, and older adults. It is not clear if they discussed the ideas with the target population of pregnant women.

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 wants to learn if they can reduce health disparities, increase mental health screenings and assessments, improve parenting and bonding behaviors for pre- and post-partum patients and their children, reduce mental health stigma, initiate and improve community collaboration all in an effort to achieve positive outcomes for expecting and post-partum mothers and their children. The County plans on hiring a third-party evaluation to use quantitative measures; such as the Patient Health Questionnaire-2 and 9 and the Adverse Childhood Experience screening tools in addition to parenting/bonding and stigma pre- and post-questionnaires, interviews, and surveys; to determine improvements. In addition, they will provide qualitative parent/guardian bonding/parenting reports. The County may wish to explore further how they will quantify the parent/bonding and stigma reduction experience amongst the perinatal and post-partum women.

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 $918,920 for five (5) years to be approved for MHSA Innovation. The County direct costs are minimal given they intend to contract the entire project to MACT and to a third-party evaluator.

The County has indicated they will only use 12% ($114,131) of the total budget to cover some of the personnel costs of their MHSA Programs Coordinator and Behavioral Health Director (1/6 of their salaries each).

A total of $125,000 will be allocated to the third-party evaluator to conduct the evaluation of the entire Innovation project (14% of the total budget).

The County is requesting $66,000 (7% of the total budget) for operating costs to purchase laptops/tablets, office supplies, continuing education/training, licensing costs, software, and incidentals.

The County is requesting to contract out 68% ($613,782) of the total budget to the MACT clinic to hire a 1.0 FTE Clinician and cover a portion of the salary of the Director of Behavioral Health of the MACT Clinics (Alex Abarca, LCSW) to provide supervision. It is unclear what the specific salary is for the 1.0 FTE and the portion set aside for the Behavioral Health Director. The County will need to provide more details on the breakdown of the funds contracted out to MACT. The County states the budget was determined by MACT. The County may wish to provide additional details on how they vetted the requested salary to fair market rates.

Additional Regulatory Requirements

The proposed project meets the minimum regulatory requirements as stated in MHSA Innovation regulations.

References

http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

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10877 Conductor Boulevard, Suite 300 • Sutter Creek, CA 95685 • Phone (209) 223-6412 • Fax (209) 223-0920 • Toll Free Number (888) 310-6555

Amador County Behavioral Health Innovations Project Brief

Name of INN Project: Circle of Wellness: Mother, Child, Family
Total INN Funding Requested for Project: $918,920
Duration of Project: 5 Years (7/1/17 through 6/30/22)

Introduction:
Amador County Behavioral Health Services is proposing a partnership with the MACT Health Board, Inc. (MACT) Clinic to provide prevention and early intervention services in a primary care setting to pregnant patients and their children. MACT is a tribal consortium providing Medical, Dental, and Behavioral Health (BH) services to American Indians and Alaskan Natives (AI/AN) as well as Non-Native patients in the surrounding community. MACT has four medical and three dental clinics spread out in the four rural Sierra foothill counties of Mariposa, Amador, Calaveras and Tuolumne. This project would specifically target pregnant patients of the MACT Clinic in Amador and implement new protocols that would normalize behavioral health treatment in primary care settings throughout pregnancy, post-partum and then annually for the child.

The Board of Supervisors in conjunction with the FY16/17 MHSA Annual Update approved this project on November 22, 2016. The Mental Health Services Oversight and Accountability Commission will consider the project for approval on May 25, 2017.

The Need:
In early 2015, community members from various agencies created the Amador-Calaveras Perinatal Wellness Coalition. Significant representation from both counties helped construct the coalition, which works towards a vision of "improved mental health and wellbeing for Amador and Calaveras families before and after delivery." Before the coalition formed, advocates were working independently in our counties to raise awareness regarding maternal mental health and the effects it had on the family as a whole. Additionally, various public agencies and private organizations were also working in a silo fashion to address the need of maternal mental health in our communities. Organizing the Amador-Calaveras Perinatal Wellness Coalition was a way for all of the independent efforts to come together on a united front. By coming together, the stakeholders in both counties are able to send a consistent message regarding the following: professional development and education, community awareness and education and the promotion and implementation of screening, referral, support and treatment.

In Amador County, approximately 283 births occur each year. 2.4% of the babies born are to teen mothers. 24.3% of the children born, aged 0-5, are living in poverty. Child Abuse and Neglect is substantiated at 39.7% for children aged 0-5 and general neglect is the leading cause of child abuse at 47.1%. In Amador County alone, Depression is 5% higher than the state (Amador 29%; CA 24%), Bipolar Disorder is 8% more prevalent than the state (Amador 22%; CA 14%) and Anxiety Disorders are 9% more prevalent at a rate of 20% (CA is 11%).

An average of 6 or 2.1% of AI/NA births occur in Amador County each year. Amador County also has three federally recognized tribes within our small geographic area. The Buena Vista Rancheria, Me-Wuk Indians; the Ione Band of Miwok Indians and the Jackson Rancheria, Mi-Wuk Indians. Historically, no formal partnership or outreach efforts have ever been explored between Amador County Behavioral Health Services and any native

organization within our community, which is unfortunate due to the tremendous need. As data at the national and state levels show, prevalence rates for substance abuse, mental health issues, and violence among our natives are significantly higher than national and state averages. Stigma among the native population has also been noted to be higher and proves to be a barrier for those individuals seeking treatment.

The Amador-Calaveras Perinatal Wellness Coalition has promoted the use of screening tools throughout pregnancy and post-partum, as an avenue to connect at-risk mothers to needed resources. Because of the coalition's efforts, screenings have been implemented in the major OB/Gyn and pediatric offices in Amador County. Education, training and in-home support has also been provided to community members who have access to pregnant mothers and their families. Although systems change have occurred to screen for those who suffer from mental health challenges during pregnancy and post-partum, the need is still not being addressed in its entirety.

The statistics stated above are significant and make a very clear argument that a more preventative approach is required to assist in reaching those who are at-risk or suffering from mental illness.

The Response:
This Innovations project will address the full spectrum of pregnancy and early childhood by developing a routine mental health protocol for pregnant women of the MACT Clinic and their children.

This project proposes a partnership between the MACT Clinic and ACBHS that enhances community collaboration with many community partners. Through this partnership, the project will support the normalization of behavioral health interventions during pregnancy and post-partum to not only mother but the child as well. The proposal includes that preventative mental health care will be provided to pregnant women who are patients of the MACT Clinic (native and non-native). The services will target education, support and treatment in order to reduce stress and maintain mental health in the mother and infant throughout pregnancy. Five appointments for each woman (if not more) will be offered. The appointments will be initiated at the onset of pregnancy and continue once each trimester, and post-partum. More appointments will be offered if needed. Additionally, the creation of mental health well checks will also be added into normal protocol on an annual basis for mother and child. Even if mental health challenges do not arise throughout the course of pregnancy or early in the child's life, tools, education and resources will be provided in a setting that is familiar and safe and the stigma associated with mental health treatment will be reduced.

The primary goal of this project is interagency collaboration related to mental health services, supports and/or outcomes. We plan to attain this goal by creating a new protocol for preventative mental health treatment in a primary care setting, utilizing partnering agencies to ensure success. Other goals of this project aim to reduce stigma among the Native Americans in our community, provide effective early intervention services to mothers and children in a primary care setting. Circle of Wellness: Mother, Child, Family also aims to create new protocols where pregnant women and children are seen routinely for 'mental health wellness' checkups as opposed to waiting for a screening to initiate treatment and to create a sustainable program that meets the mental health needs of the mother, child and family.

An overarching goal of Circle of Wellness: Mother, Child, Family is to build a seamless system that bridges the gaps between primary care and OB/Gyn offices that will increase access to mental health services that can be replicated in other settings.

Community Planning Process:
The community planning process began in May 2016 when the Director of Behavioral Health at the MACT Clinics, approached Behavioral Health with this innovative idea.

The Innovations proposal was originally presented at the June 14, 2016 MHSA/Cultural Competency Steering Committee Meeting as a part of the Community Planning Process for the FY16/17 Annual Update. This topic was also discussed again at the September 1, 2016 MHSA/Cultural Competency Committee Meeting when we were discussing the finalization of the FY16/17 Annual Update. On both occasions, feedback from stakeholders was positive and it was noted that this project is 'exciting' and 'a great way to reduce stigma.' It should be noted that the MHSA/Cultural Competency Steering Committee is composed of various community partners, stakeholders and county staff. A wide array of populations throughout the county are present, including the County's most underserved populations--Native Americans and Hispanic/Latinos. Furthermore, since Amador County is a very rural and widespread county, representation from underserved rural areas, Veterans, Children, TAY and Older Adults are also present at these meetings and participated in the stakeholder process. This topic was again discussed at the July NAMI Amador meeting. The Innovations proposal was also shared at the Amador County Behavioral Health Advisory Board meeting in October 2016 when the Public Hearing for the FY16/17 Annual Update was held.

Additionally, the Innovations proposal was presented at the June 2016 Perinatal Wellness Coalition meeting where feedback was again positive. More recently, at the April 2017 Perinatal Wellness Coalition meeting, the Innovations Workgroup asked coalition members to think of a creative name for the proposed project. The project name, Circle of Wellness: Mother, Child, Family was created by one of the coalition members.

As illustrated above, extensive stakeholder and community input was received regarding this Innovations project. Plans to keep the community and stakeholders apprised of the project will continue throughout the five-year pilot by utilizing the Innovations Workgroup, the Perinatal Wellness Coalition and the MHSA/Cultural Competency Steering Committee meetings.

Budget & Timeline:
This project will be funded for five years utilizing Mental Health Services Act Innovation funds. The total cost for the five-year project is $918,920. Included in the total cost are personnel costs, equipment, licensing and ongoing training expenses. The total cost also includes a contract for a third party evaluator to assist with data collection methods, analysis and reporting. The third party evaluator will also work as partner to assist in building capacity so that infrastructure built during the pilot years is sustainable without Innovations funding. Additionally, the evaluator will also work with the Innovations Workgroup in developing the work plans and annual reports that meet regulatory requirements. The project timeline and cost for each year is detailed below:

Year 1 (7/1/17 through 6/30/18)—Planning:
Year 1 Cost: $173,212
The first year of this project is intended to be a planning year. The planning will be a collaborative effort on behalf of the Innovations Workgroup and the MACT Clinic to create the following:

- Identify a 3rd Party Evaluator to assist in project development and foundational structure
- Develop interventions-algorithm; core components
- Develop protocols (referral protocol between agencies/organizations; ROI's; etc.)
- Develop MOU's between to formalize interagency collaboration and accountability
- Identify data collection methods and protocols
- Develop and streamline measurable project goals
- Start delivering services, utilizing the developed protocols, interventions and data collection methods identified in the planning phase

- Continuous attendance and ongoing reporting and involvement of stakeholders at the MHSA/Cultural Competency Steering Committee meetings and Amador-Calaveras Perinatal Wellness Coalition meetings

Year 2 through 4 (7/1/18 through 6/30/21)—Implement Practice:
Year 2 Cost: $177,008
Year 3 Cost: $183,146
Year 4 Cost: $189,532
The second, third and fourth year of this project will be the actual pilot years of this project where the practices identified and developed in year 1 are implemented.

- Implement practice
- Innovations Workgroup will meet quarterly to review data, identify challenges, lessons learned and discuss opportunities for improvement or change
- Continuous attendance and ongoing reporting and involvement of stakeholders at the MHSA/Cultural Competency Steering Committee meetings and Amador-Calaveras Perinatal Wellness Coalition meetings
- Annual project evaluations and reviews will be completed and analyzed with the assistance of the third Party Evaluator. All evaluations, data, outcome measures, etc. will be delivered to stakeholders on an ongoing, regular basis.

Year 5 (7/1/21 through 6/30/22)—Final Review and Sustainability Plan:
Year 5 Cost: $196,022 The fifth year will be dedicated to the final review while continuing service delivery as demonstrated in years two through four. During the final year, complete review will be conducted. Successes, lessons learned and other data will be reviewed to determine what elements should be included in the sustainability plan. A comprehensive sustainability plan will be completed which will define what the program will look like moving forward. The Sustainability Plan will include fiscal accountability, maintenance of data collection methods and analysis and ongoing identification of resources and partners necessary to ensure continued success.
Throughout the final year, all stakeholders will continue to be involved in meaningful way utilizing the Innovations Workgroup, the MHSA/Cultural Competency Steering Committee and the Perinatal Wellness Coalition.

Conclusion:
Circle of Wellness: Mother, Child, Family is an innovative project for Amador County as it will create an entirely new protocol for the way we address mental health issues in pregnant women and children. It will bring organizational collaboration together and formalize partnerships that otherwise would not have been pursued. By normalizing mental health treatment in primary care settings, we believe that we can increase access to services, educate and equip mothers in their journey as parents, reduce stigma among our native population and create healthier individuals within our community.

STAFF INNOVATION SUMMARY — AMADOR COUNTY

Name of Innovative (INN) Project: Co-Occurring Group for Teens

Total INN Funding Requested for Project: $787,686

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: November 22, 2016
County Submitted Innovation (INN) Project: May 5, 2017
MHSOAC Consideration of INN Project: May 25, 2017

Project Introduction:

Amador County proposes using Innovation funds to provide a co-occurring group co-facilitated by a substance abuse counselor and a mental health clinician to Transition Age Youth (TAY) (age 16-25) currently receiving substance abuse treatment at a center. The County states the two staff will either use established curriculum used in their field or evidence-based practices already established as successful with this population. The County proposes serving about five TAY clients per year. Their budget is to partially cover the salary of the substance abuse counselor, the mental health clinician, and the case manager who will offer case management services to the TAY in the co-occurring group.

In the balance of this brief we address specific criteria that the MHSOAC 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 MHSOAC 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

Amador County, a small rural county, reports seeing an increase in teen youth seeking treatment through their behavioral department for substance abuse issues. Between 2013 and 2015, Alcohol and Drug Counselors saw eight (8) teens in substance abuse treatment of which six (6) (75%) of them were also enrolled for services at the mental health department, two (2) of them specifically receiving Full-Service Partnership (FSP) services. They report seeing a 25% increase in 2015 with ten (10) teens seeking

substance abuse treatment and the same percentage of these youth also receiving services at the mental health treatment department and FSP programs. It seems the County developed a new youth treatment group at this time to address the increasing number of teens seeking treatment. They report twenty-two (22) youth have completed the substance abuse program over the past three (3) or so years with four (4) successfully graduating. It is unclear what the difference is between completing and graduating from a program. The County has not provided details on this treatment group and may wish to share what successes have been obtained through providing the substance abuse treatment group and what barriers remain leading them to develop a new innovation project.

The County states the behavioral health and mental health department remain in silos. The County may wish to discuss collaborative efforts and strategies they have tried to reduce this separation between treatment services for their TAY youth and how these strategies were taken into consideration when developing this innovation plan.

The Response

It appears the County seeks to hire a mental health clinician and substance abuse counselor to co-facilitate a co-occurring group located at the substance abuse treatment program. They report intending to provide transportation to and from groups, one-on-one case management services, and psychoeducational parenting groups. They report wanting to create a pilot to test for success at this location to then replicate through Amador County in their schools, school affiliated programs, faith-based organizations, and other community organizations. The County reports the pilot program will work with at least five (5) TAY participants annually.

The County states they want to test how successful this co-occurring group will be if the teen is receiving it while in treatment at both the substance abuse and mental health treatment programs. They also state the County has never provided mental health services in their substance abuse treatment programs nor case management to their clients seeking substance abuse treatment. Given the County’s concern about siloed treatment, they may wish to share more information on how they hope to also improve communication between treatment providers. Furthermore, the County will need to discuss the novelty in providing mental health services and case management in their substance abuse treatment program when other counties and programs have been offering these services for many years.

The County also reports the substance abuse counselor and mental health clinician will be using practices and techniques which have been determined to be effective in other settings and successful in the treatment of AOD and mental health issues. This will include the use of incentivizing abstinence techniques, a practice endorsed by the National Institute on Drug Abuse as an effective treatment for this population. The County may wish to discuss what new knowledge will come forth by providing these groups over a course of five years rather than during shorter timeframe and using established best practice for the treatment of mental health and substance abuse.

Co-facilitating groups has been a practice embedded in primary care, mental health, behavioral health, and substance abuse treatment for many years. Groups addressing co-occurring mental health and substance abuse issues has also been a practice used throughout the State even prior to the Mental Health Service Act. It appears the County may have only reviewed other Innovation plans and are stating they have not found programs focusing on transition-age youth (TAY). Research does indicate certain variables need to be considered when providing mental health and substance abuse treatment to this population, including flexibility of time to support school attendance, the value of peer support, and utilization of best practices such as Motivational Interviewing, Cognitive Behavioral Therapy, and Multi-family support. These are some of the best practices recommended by the State for substance abuse treatment programs applying for Drug Medi-Cal certification. The County has provided limited details on how their innovation project will bring TAY-specific services to this population and if they will be considering Drug Medi-Cal as a funding source to support this need in their County.

The Community Planning Process

The MHSA regulations indicate stakeholder participation will be present at every step of the way for the Innovation project, 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 the County states their CPP was extensive, they may wish to share how the idea was developed given it appears to have been presented by the Behavioral Health Department as a part of the Community Planning Process for their 16/17 MHSA Annual Update. The CPP appears to include a wide array of ethnic populations, and under-represented stakeholders such as older adults, Veterans, and TAY; it appears to be lacking departments involved with youth, including probation, schools, and substance abuse treatment centers.

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 evaluation will be contracted out to The Strategies Center of California. The County provided limited details on what will be evaluated. They will review the reasons for discharge from treatment and utilization of services through their electronic health record to determine if the TAY participant completed the program successfully. This does not appear to be a robust methodology and seems similar to what they have used in the past

to measure success from a treatment program. The County only wrote the comprehensive plan for evaluation that will be presented to the Commission at the May meeting. Therefore, it is unclear how the County met the minimum Innovation regulation requirement of providing an evaluation plan for the public to view, the local planning process to approve, and the MHSOAC staff to consider when preparing for the Commission meeting.

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 $787,686 for five (5) years to be approved for MHSA Innovation. It appears they are also anticipating leveraging Federal Financial Participation in the amount of $75,000 for five (5) years.

A total of $125,000 (16%) will be allocated to The Strategies Center of California for evaluation. The percentage is significantly more than other innovation plans (typically around 5-7%) and raises some concern given the County has not provided details on their evaluation plan.

The County is requesting $70,000 (9% of the total budget) for operating costs; including continuing education, training, licensing costs, curriculum development, stipends/ incentives for the incentivizing abstinence techniques, and hardware computer equipment and software.

The County is requesting the following personnel costs (totaling $582,686 or 74% of the total budget) to be covered:

- 17% of the County's Behavioral Health Director's salary (oversight of project)
- 17% of the County's MHSA Coordinator's salary (oversight of project)
- 25% of an AOD Supervisor's Salary (oversight of project)
- 25% of a Substance Abuse Counselor's Salary (co-facilitate group)
- 25% of a Mental Health Clinician's Salary (co-facilitate group)
- 25% of a Personal Services Coordinator's Salary (case management)

It is unclear if these are new items, what their annual salary is, and how the County intends to cover the rest of the cost and why that funding source cannot cover the entire personnel costs. The County also stated in the budget details that they are requesting MHSA Innovations to cover all the salary costs associated with this project (with the exception of $10,000 per year through Medi-Cal claiming). The County may wish to clarify the personnel section of their budget request.

Additional Regulatory Requirements

The proposed project does not meet the minimum regulatory requirements as stated in MHSA Innovation regulations given it did not include their evaluation plan, which they state will be presented at the Commission meeting.

References

https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment

http://www.kidsdata.org/topic/165/juvenilearrest-rate/table#fmt=2332&loc=1763&tf=84&sortColumnId=0&sortType=asc

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10877 Conductor Boulevard, Suite 300 • Sutter Creek, CA 95685 •
Phone (209) 223-6412 • Fax (209) 223-0920 • Toll Free Number (888) 310-6555

Amador County Behavioral Health Innovations Project Brief

Name of INN Project: Co-Occurring Group for Teens
Total INN Funding Requested for Project: $787,686
Duration of Project: 5 Years (7/1/17 through 6/30/22)

Introduction:
Amador County Behavioral Health Services (ACBHS) is proposing an Innovations project that introduces a new mental health approach that will promote interagency collaboration related to mental health services, supports, and outcomes. This project target the teenage population who are participating in the Youth Substance Abuse Treatment Program while simultaneously receiving mental health treatment.

This Innovations project would allow ACBHS to pilot a youth Substance Use Disorder (SUDS) treatment program with an added therapeutic element by treating co-occurring disorders at the same time. The plan would be to develop a curriculum, utilizing both SUDS and mental health treatment staff, to see if positive outcomes for our co-occurring teenage youth population increase. A team approach, consisting of one MH Clinician and one SUDS Counselor to co-facilitate these groups would be created with the goal that over time, both the youth's Mental Health and Substance Abuse outcomes will improve.

The Board of Supervisors in conjunction with the FY16/17 MHSA Annual Update approved this project on November 22, 2016. The Mental Health Services Oversight and Accountability Commission will consider the project for approval on May 25, 2017.

The Need:
Amador County Behavioral Health Services (ACBHS) has seen an increase in the need for behavioral health services specifically targeted to our teenage youth. Over the past few years, an increasing trend has presented itself in the numbers of teenage youth who participate in the SUDS Youth Treatment program while simultaneously receiving mental health treatment.

- In fiscal year 2013/14 and 2014 /15, Alcohol and Drug Counselors saw eight teenagers individually within the behavioral health department. 75% of these teens were also receiving outpatient mental health treatment at the same time. 25% of the teens receiving substance abuse services were also participating in Amador County Behavioral Health's Full Service Partnership (FSP) program.
- In fiscal year 2015/16, the number of teens requiring alcohol and drug treatment doubled to ten. As a result of the increased need, a youth treatment group was developed. Half of the teens who were participating in the newly created youth program were also receiving outpatient mental health treatment and 20% were participating in the FSP program.
- We are now in fiscal year 2016/17 and data from July 1, 2016 through March 31, 2017 shows that nine individuals have or are currently receiving substance abuse treatment. The numbers have increased to show that now 77% of these teenagers are also receiving outpatient mental health treatment and 22% are participating in the FSP program.

Additionally, the Amador County Community Needs Assessment which was completed in August 2014 identified the following: *"Amador County's 11th grade self-reported alcohol use and tobacco use was higher than the state and similar rural counties. The 11th grade alcohol and other illegal drugs use (combined) was also high when compared to that of the state and Tuolumne County. Amador County eleventh grade students reported using prescription drugs recreationally more than their peers."*

It is apparent that ACBHS needs a more effective approach when it comes to service delivery for at-risk and high-risk youth. At this time, the department is treating teens who suffer from mental health challenges and substance abuse issues in a silo fashion. The youth will go through and attend appointments and groups separate from each other. In some cases, the mental health and substance abuse providers will not discuss mutual clients. Therefore, no collaboration is taking place when it comes to guiding the treatment of these teens who are suffering from co-occurring mental health and substance abuse problems. As a result, of the 22 youth who have completed the substance abuse program over the past 3 ½ years, only 4 have successfully satisfied the program requirements and graduated successfully.

The Response:
The proposed project will create a co-occurring group targeted to the teenage youth population receiving services at Amador County Behavioral Health. The group would be co-facilitated by a mental health clinician and a substance abuse counselor to address both the substance abuse and mental health challenges at the same time.

The proposed project will include incorporating practices and techniques that have been determined to be effective in other settings to treat both diagnoses. Other components of this project would include incorporation of a case manager to provide one-on-one support and follow-up as necessary as well as transportation services. In order to increase support and education around teens and co-occurring disorders, a healthy adult component for parents and support persons will be incorporated into the project as well.

There is an intense need within Amador County to create services directed toward youth that promote wellness and resiliency. This project will guide the client to create mechanisms that assist them in maintaining their wellness and recovery within their own lives. Assisting the clients to gain insight as to what their basic values are and what is required of them to be well will promote resiliency into early adulthood and carry into the rest of their lives.

The ultimate goal of the proposed project is to determine if by using utilizing this group and treating both the substance abuse and the mental health diagnoses at the same time, we can improve outcomes among the teens and transitional-aged youth in Amador County.

Community Planning Process:
The Community Program Planning process for the Innovative project has been an extensive process. In Spring 2016, community input was gathered for the FY16/17 MHSA Annual Update. In the community program planning phase of the FY16/17 MHSA Annual Update, a survey was issued that included a description of the proposed Innovations project and requested feedback from community members. Responses to the Innovations project were mostly positive with an average of 47% indicating 'Maybe So' or 'Definitely Yes' in supporting this project.

Subsequently, the project was presented at various stakeholder and community meetings. In June and July 2016, the project was discussed at the MHSA/Cultural Competency Steering Committee meeting and received positive feedback. Furthermore, detailed discussion regarding the project continued at the September MHSA/Cultural Competency Steering Committee Meeting as well. It should be noted that the MHSA/Cultural

Competency Steering Committee is composed of various community partners, stakeholders and county staff. A wide array of ethnicities are represented, including the County's most underserved populations--Native Americans and Hispanic/Latinos. Furthermore, since Amador County is a very rural and widespread county, representation from underserved sub-populations such as, Veterans, Children, TAY and Older Adults were also present at these meetings and participated in the stakeholder process. In order to keep the stakeholders and community partners involved in this project, Innovations is now a standing item on the agenda for each MHSA/Cultural Competency Steering Committee Meeting. Additionally, this project was also presented to NAMI Amador at their monthly meeting in July 2016. This project sparked more discussion around general services for youth within our county and the lack thereof. Overall, it was a positive conversation and the project was well received.

The Innovations proposal was also discussed at the Amador County Behavioral Health Advisory Board meeting in October 2016 when the Public Hearing for the FY16/17 Annual Update was held. More recently, Behavioral Health Advisory Board members have shown more interest in substance abuse prevention and treatment within the County and as a result, this Innovations project was recently discussed at the April 2017 Behavioral Health Advisory Board meeting and was a welcome intervention to assist in meeting the substance abuse needs in the county, especially among the youth.

Continual involvement of community partners, stakeholders, consumers and staff is an integral part of the projects success and a core value of the projects integrity within the community. ACBHS will continue to demonstrate efforts to involve and inform the community about the proposed project and its progress.

Budget & Timeline:
This project will be funded for five years utilizing a combination of Mental Health Services Act Innovation funds and reimbursements from Medi-Cal billing. The total cost for the five-year project is $787,686. This project will be done internally and the total costs includes personnel costs, equipment, licensing and ongoing training expenses. The total cost also includes a contract for The Strategies Center of California, a third party evaluator to assist with data collection methods, analysis and reporting. Strategies Center of California is also working as partner to assist in building capacity so that infrastructure built during the pilot years is sustainable without Innovations funding. Additionally, The Strategies Center of California will also work with the Innovations Workgroup in developing the work plans and annual reports that meet regulatory requirements. The project timeline and cost for each year is detailed below:

Year 1 (7/1/17 through 6/30/18)—Planning:
Year 1 Cost: $152,891

The first year of this project is intended to be a planning year. The planning will require interagency collaboration from the SUDS and Mental Health teams to create the following:

- Identify an evidence-based practice (EBP) that fits the needs of the project and train staff appropriately to use the EBP;
- Develop a curriculum (if an EBP cannot be identified);
- Develop interventions-algorithm; core components
- Develop protocols (referral protocol)
- Develop MOU's between to formalize interagency collaboration and accountability, if necessary
- Identify data collection methods and protocols
- Develop and streamline measurable project goals
- Start delivering services, utilizing the developed protocols, interventions and data collection methods identified in the planning phase

- Continuous attendance and ongoing reporting and involvement of stakeholders at the MHSA/Cultural Competency Steering Committee meetings, Amador County Behavioral Health Advisory Board Meetings and Internal Team Meeting within ACBHS

Year 2 through 4 (7/1/18 through 6/30/21)—Implement Practice:
Year 2 Cost: $154,287
Year 3 Cost: $157,905
Year 4 Cost: $160,775

The second, third and fourth year of this project will be the actual pilot years of this project where the practices identified and developed in year 1 are implemented.

- Implement practice
- The PIP Team meeting will meet bi-weekly to review data, identify challenges, lessons learned and discuss opportunities for improvement or change
- Continuous attendance and ongoing reporting and involvement of stakeholders at the MHSA/Cultural Competency Steering Committee meetings, Amador County Behavioral Health Advisory Board Meetings and Internal Team Meeting within ACBHS
- Annual project evaluations and reviews will be completed and analyzed with the assistance of the 3rd Party Evaluator, The Strategies Center. All evaluations, data, outcome measures, etc. will be delivered to stakeholders on an ongoing, regular basis.

Year 5 (7/1/21 through 6/30/22)—Final Review and Sustainability Plan:
Year 5 Cost: $161,828

The fifth year will be dedicated to the final review while continuing service delivery as demonstrated in years two through four. During the final year, complete review will be conducted. Successes, lessons learned and other data will be reviewed to determine what elements should be included in the sustainability plan. A comprehensive sustainability plan will be completed which will define what the program will look like moving forward. The Sustainability Plan will include fiscal accountability, maintenance of data collection methods and analysis and ongoing identification of resources and partners necessary to ensure continued success.

Throughout the final year, all stakeholders will continue to be involved in meaningful way. The Final Report and Sustainability Plan will be reviewed by the stakeholders using the avenues (at minimum) listed in 8b above, prior to formal approval and presentation.

Conclusion:
Co-Occurring Group for Teens is an entirely new approach for Amador County Behavioral Health Services that truly promotes interagency collaboration. Combining the worlds of substance abuse and mental health to create a group that could significantly improve outcomes will truly bridge the gap between Substance Abuse and Mental Health within our agency and provide a more fluent, integrated service experience for the teens and their families.

AGENDA ITEM 6

Action

May 25, 2017 Commission Meeting

Ventura County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Ventura County's request to fund a new Innovative project: Children's Accelerated Access to Treatment and Services (CAATS) for a total of $2,670,777 in Innovation component funding over three (3) years. Ventura County proposes to increase the quality of mental health outcomes for foster youth by moving its current mental health screening and referral service model provided by their child welfare staff over to a newly hired behavioral health staff under the Children's Accelerated Access to Treatment and Services (CAATS) project.

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 County will be implementing an assessment team consisting of a 1.0 FTE clinical supervisor, 3.0 FTE clinicians, and 1.0 licensed vocational nurse (LVN). The clinicians will administer a well-established assessment tool, the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment, to assess and link foster youth to mental health services. The County intends to offer a well-established evidence-based practice, Trauma-Informed Cognitive Behavioral Therapy (TF-CBT), to all youth entering the foster care system regardless of their severity of mental health issues. The LVN will provide education to foster parents on the importance of and effective ways to monitor their foster child's medication routine.

Presenters: Kiran Sahota, MA Mental Health Services Act Manager; Dina Olivas, LCSW Behavioral Health Manager; Hilary Carson, MSW MHSA Administrator, Innovations

Enclosures (3): (1) Ventura County Innovation Plan Presenters; (2) Staff Innovation Summary, Children's Accelerated Access to Treatment and Services; and (3) 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/2017-05/ventura-county-inn-plan-description-childrens-accelerated-access-treatment-and

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

Name: Children's Accelerated Access to Treatment and Services
Amount: $2,670,777
Project Length: Three (3) Years

Ventura County Innovation Plan Presenters

Kiran Sahota, MA
Mental Health Services Act Manager
Ventura County Behavioral Health
Kiran has managed all MHSA activities in Ventura County since 2015. She has worked in Ventura County Social Services for over 20 years. She has experience in the child welfare system, law enforcement, and community collaboration. Her advanced education is in Clinical and Community Psychology.

Dina Olivas, LCSW
Dina has worked in the field of Mental Health for the last thirty-one years and relocated to Ventura County in 2001. She has experience in the field of Infant Childhood Mental Health, Maternal and Adolescent Mental Health, and Program Development in the Latino community. Currently, she is a Behavioral Health Manager responsible for community-based mental health services for dependency children, youth and families who are a part of the Child Welfare System.

Hilary Carson, MSW
MHSA Administrator, Innovations
Ventura County Behavioral Health
Hilary received her MSW from NYU in Policy and Programs; she has a background in working with Community-Based Organizations specializing in parents and families involved in the criminal justice system. She joined Ventura County Behavioral Health in June 2016.

STAFF INNOVATION SUMMARY—VENTURA COUNTY

Name of Innovative (INN) Project: Children's Accelerated Access to Treatment and Services (CAATS)

Total INN Funding Requested for Project: $2,670,777

Duration of Innovative Project: Three Years

Review History

Approved by the County Board of Supervisors: Pending, to be approved on May 23, 2017

County Submitted Innovation (INN) Project: March 15, 2017

MHSOAC Consideration of INN Project: May 25, 2017

Ventura County proposes to increase the quality of mental health outcomes for foster youth by moving its current mental health screening and referral service model provided by their child welfare staff over to a newly hired behavioral health staff under the Children's Accelerated Access to Treatment and Services (CAATS) project. The County will be implementing an assessment team consisting of a 1.0 FTE clinical supervisor, 3.0 FTE clinicians, and 1.0 licensed vocational nurse (LVN). The clinicians will administer a well-established assessment tool, the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment, to assess and link foster youth to mental health services. The County also intends to offer a well-established evidence-based practice, Trauma-Informed Cognitive Behavioral Therapy (TF-CBT), to all the youth entering the foster care system regardless of the severity of their mental health issues. The LVN will provide education to foster parents on the importance of and effective ways to monitor their foster child's psychotropic medication routine.

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

The Need

The County reports a total of 961 youth in the foster care system in 2014 (4.0 per 1,000) with a higher rate of entry seen amongst African American children at 6.1 per 1,000. Based on the data provided on Kidsdata.org, Ventura has seen a decrease in children in the foster care system in 2015 (3.8 per 1,000) and is similar to neighboring Santa Barbara County (3.7 per 1,000) but significantly lower than the state's rate of 5.8 per 1,000 and comparable counties of Kern (6.0 per 1,000) and San Luis Obispo (5.1 per 1,000) in the same year. Ventura appears to be maintaining a plateau of children in the foster care system since early 2000s, with a drop between years 2002-2010. It will be beneficial for the County to provide additional information on strategies implemented during this time leading to a reduction of children in the foster care system, hence less youth needing mental health services.

According to the County, a Children and Family Services (CFS) social worker sends a referral to the Child Welfare Subsystem, a newly established specialized program under the County's Behavioral Health Department. A Subsystem child welfare provider then conducts a biopsychosocial mental health screening and assessment on the child entering the foster care system to determine if the child needs to then be referred to a clinician in the Behavioral Health Program for a thorough clinical assessment. It is unclear what mental health screening tool is used at by the Subsystem staff. The program also provides in-home, community based mental health services in the home with the foster family. It is unclear what mental health practices are currently provided by the team. Furthermore, according to the County's website, newly designed Family Team Meetings (FTM) are provided to bring together clinicians, child welfare social workers, public nurses, community-based organizations, and families to work collaboratively to ensure trauma-informed care is provided to the child in a family setting.

The County reports struggles with providing oversight of the administration of medication for foster youth, thus leading to poor mental health outcomes. As a designated Mental Health Profession Shortage Area (HPSA), the United States Health Resources and Service Administration has recognized Ventura County as having too few mental health providers to meet the needs of the community. The same data source indicates their neighboring county, Santa Barbara, has a higher shortage of mental health professional available to meet their county needs. Given their shortage of mental health providers, Ventura County may want to provide information on the County's capacity to provide mental health services more rapidly to meet the increase demand which may occur with a faster identification of the mental health needs in youth in the foster care system.

The County reports their current referral process can be slow, lack comprehensiveness and delay the provision of services and appropriate placements. To better understand the need for to adapt this process, the County may wish to discuss the duration of time between the Child Welfare Subsystem program staff receiving a referral from the Children and Family Services social worker and setting up the assessment. The County may wish to discuss any strategies and collaboration utilized to improve the process between the Children and Families Department and Behavioral Health Department and reasons for limited improvement in duration of referrals. The County may wish to discuss the duration

of time between completing an assessment and starting mental health services for the child in the foster care system and what barriers are present preventing more timely access to all these assessment and mental health services for this target population. The County could benefit on explaining the specific limitations of their current screening tool and in-home mental health services used by their Child Welfare Subsystem. They may wish to discuss the shortcomings of the Family Team Meetings and the services provided by the public health nurse in comparison to the newly proposed LVN on the new assessment team.

The Response

It appears the County proposes they will demonstrated better mental health outcomes amongst their youth in foster care by changing their current assessment and referral process through hiring a new team and using a different assessment tool and an evidence-based practice. The County states they will hire 3.0 FTE clinicians and train them in the available county and community based services and resources and the CANS assessment tool to prepare them to assess a child entering the foster care system and link them to appropriate services. The County states the new team will be able to conduct these assessments in the homes as well to create a less clinical setting for the child and family. The new team will complete the assessment and make recommendations for services as needed within 10 days of receiving a referral from the Children and Family Services social worker.

The CANS is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in the child welfare, mental health, juvenile justice, and early intervention systems in 50 states. CANS has been shown to be a valid outcome measure in residential treatment, intensive community treatment, foster care and treatment foster care, community mental health and juvenile justice programs. It is flexible enough to be augmented to fit cultural needs and can be administered by individuals from different backgrounds; including mental health providers, child welfare case workers, probation officers, and family advocates. According to the John Praed Foundation, the developer of the CANS tool, counties such as Fresno, San Bernardino, Los Angeles, Santa Clara, San Francisco, and Sonoma are using the CANS to better assessment the mental health needs of their children and youth.

It is unclear what will be the role of the Child Welfare Subsystem program staff, who provide the same services at this time, with the development of this new assessment team. Furthermore, the County may want to share more information on how the referral, assessment, and linkage process will change with the new assessment team and how the team will be incorporated into the current intake process. It is unclear where will they be located and how the new assessment team's communication with the Child and Family Services social worker will be different and improved from the current process with the Child Welfare Subsystem staff. Also, given the versatility of the CANS, it is unclear how the same rapid linkage to mental health service within 10 days could not result by providing the Subsystem program staff the training on the CANS and ensure they are

trained on the available county and community-based resources.

The County has also not provided information on the benefit of hiring licensed staff and training them in a well-established evidence-based practice, Trauma-Focused Cognitive Behavioral Therapy. This practice is included in the California Evidence-Based Clearinghouse for Child Welfare and used across the state, including Los Angeles and San Bernardino County, to provide more trauma-informed care to this population. It is unclear if the new assessment team will be providing ongoing therapy and what new knowledge using the widely used EBP for youth in the foster care system will bring to the mental health field. The County also shared they significantly expanded the mental health services, including therapy, to children and youth living in foster care as a result of the Katie A lawsuit. The County stated they went above and beyond the requirements to ensure better services were available to this population at the time. They also discussed how they will be using these trained Katie A staff to offer TF-CBT to the youth in foster care. The County may wish to expand upon what strengths and areas of improvement exist in this applied system change and how these improvements cannot be funded through these funding sources rather than MHSA Innovation. If Innovations is more appropriate, the County will need to expand on the learning they hope to gain with offering TF-CBT to youth who may opt out of starting therapy.

The County may wish to share if they connected with other counties to obtain technical assistance and to discuss the effectiveness of the CANS tool in better assessing the needs of this population. The County may wish to also discuss how implementing this tool in Ventura will provide new knowledge to the mental health already not achieved by other counties and states using this tool.

The Community Planning Process

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

According to the County, this project was developed as part of a larger Community Program Improvement Mapping meetings held on May 4th, 5th and June 14th. They state the obtained information from foster youth, parent partners, and foster families. The County stated an increase in African American children entering the foster care system and may wish to discuss strategies taken to gather information from this underserved population.

The project was presented at the February 27th Behavioral Health Advisory Board and released for a 30-day public review. A public hearing was held on April 17, 2017. The final plan is on consent calendar to be approved by the Board of Supervisor by May 23, 2017.

The plan appears to have primarily been developed by the County and then provided to

stakeholders for feedback. The County may wish to elaborate on the involvement of consumers and family members and representatives from the Child and Family Services department and Child Welfare Subsystems in the CPP process. The County appears to have provided a Continuum of Care reform in 2016 and may wish to share the outcome of this effort and how this reform played a role in the development of this innovation plan.

Learning Objectives and Evaluation

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

The County seeks to improve the access to quality mental health services for youth in the foster care system. What is unclear is the effectiveness (and lack of) in their current system, which includes a newly developed Child Welfare Subsystem program embedded in the Behavioral Health Department, with providers using a biopsychosocial assessment to determine if they need to then refer a youth to a mental health provider for mental health assessment. It also is unclear what the current benchmark is for the time in between completing an assessment and linking a youth to services with the County's system and outcomes indicating the youth in the County are being underserved. This appears to limit the ability to demonstrate if using a new assessment team and the CANS assessment tool will result in a 10-day turnaround of linking youth in the foster care system to mental health services. It is also unclear as to how this process will be more rapid when the youth will be seeing two County staff again for two assessments before being linked to a mental health professional for a mental health assessment to open them up for mental health services.

The County also states they want to determine if providing a mental health intervention to all foster youth improves mental health outcomes. This learning objective appears to be one sought after by many researchers with likely consistent positive results. The County may wish to discuss what new knowledge they intend to offer the mental health system through this learning objective and other clinical outcomes they will seek to demonstrate in this innovation project.

The County states they want to determine if providing support, education, and oversight from an LVN lead to more accurate prescriptions and adherence to psychotropic medication. Research indicates providing education on medication management is essential to improve adherence to and positive outcomes of psychotropic medication. Therefore, the County may wish to share what new information they intend to add to the mental health field with this learning objective.

It appears the County may wish to consider implementing a more robust evaluation process including establishing benchmarks for the current system to then demonstrate improvements based on the implementation of the new system or consider testing two

types of assessment models to see which is more effective.

The County plans to contract with Evalcorp to lead the evaluation. However, there is no budget at this time to support an evaluation for this innovation project. The County states Evalcorp completes the evaluation for all their Innovation plans and their contract will be expanded through other funds to support evaluating this Innovation plan.

The Budget

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

The County states this innovation project will cost a total of $2,670,777 for three years, of which $1,471,668 (55% of the total budget) will come from MHSA Innovation funds and the County anticipates leveraging $1,199,109 (45% of the total budget) from Federal Financial Participation (Medi-Cal match) to cover the remaining part of the total budget. The County provided a budget inclusive of both funding sources and is encouraged to share what part of the total functional costs below will be covered by MHSA Innovation dollars only.

69% ($1,851,240) of the total requested budget ($2,670,777) is allocated for personnel. The County will need to provide the budget specifically covered by MHSA Innovation:

1.0 FTE Behavioral Health Clinical Supervisor (salary only- $82,806 per year)
3.0 FTE Behavioral Health Clinicians (salary only- $78,918 per year)
1.0 FTE Licensed Vocational Nurse, Mental Health (salary only $106,014 per year)

The total benefits for the five staff is $574,523 for the three-year project. This includes a yearly 5% increase for the cost of living and inflation.

The County has allocated $102,788 (4% of the total budget) for the purchase of four vehicles to allow the staff to conduct the CANS assessments at the foster home. The County may wish to explain how these vehicles will continue to be used should the project ends if deemed ineffective.

The remaining operating cost budget totals $368,387 (14% of the total budget) and includes cell phones, liability insurance, office supplies, software, leasing, utilities, car maintenance, computer tablets, data cards, and computers. The County's operating budget is 18% of the project's total budget. It is unclear why the new assessment team cannot utilize the offices currently occupied by the Child Welfare Subsystem program staff if they will no longer be providing these assessments to the youth.

The County has not identified any funds for indirect costs or evaluation, including the consultant Evalcorp. The County reported their total administrative cost to be $348,362 (15% percent of the total budget), however calculations indicate it is 13%.

Additional Regulatory Requirements

The proposed plan does not appear to meet the minimum regulatory requirements given it is not clear what the evaluation budget is for the Innovation project.

References

Chadwick Center for Children and Families "An Approach to Screening for Mental Health and Trauma-Related Needs among Children and Youth Involved in Child Welfare Services"

Pecora, Jensen, Romanelli, Jackson, and Oritz, "Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges" Child Welfare, 2009, 88(1): 5-26.

Lyons, "Use of the Child and Adolescent Needs and Strengths (CANS) in Child Welfare in the United States" March 23, 2014

https:// datawarejpise.hrsa.gov/tools/analyzers/hpsefind.aspx accessed 4/28/2017

http://www.vchca.org/child-welfare-subsystem-foster-care

https://datawarehouse.hrsa.gov/topics/hrsainyour/customcompare.aspx

http://www.cebc4cw.org/search/topic-areas/

www.kidsdata.org

http://www.cebc4cw.org/search/topic-areas/

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Innovation Project Brief

Children's Accelerated Access to Treatment and Services (C.A.A.T.S)

Primary Problem

County and state governments have been trying to resolve the disproportionate rates that foster youth have for developing or experiencing mental health disorders for almost as long as child welfare systems have been in their purviews. Several studies have documented increased prevalence of emotional and behavioral disorders in foster care youth[1]. Similarly, Pecora et al.[2] found that up to 80% of the children in foster care require intervention for serious behavioral or mental health problems. Even more profound was the long-term findings that Pecora observed; three of five children were found to have a lifetime mental health diagnosis, and one in five had a three or more lifetime diagnosis. These studies strongly indicate that untreated children in today's child welfare system are at a high risk of developing significant mental health issues in adulthood.

Considering these significant findings, children entering the child welfare system should have their mental health needs prioritized. However, youth currently in foster care regularly face long delays in receiving clinical services despite legislation that mandates their right to treatment. In 2016, according to the California's Children Report card, only 65 percent of California's foster youth with serious emotional challenges receive the mental health services they need. Much of this issue can be contributed to long waits for assessment and service openings, but additional contributing factors identified included racial bias, child's age, and the type of placement[3]. To expand on racial bias issue, Garland, Landsverk, and Lau[4] found bias in assessment and referral patterns as well as less efficient engagement and retention of African American children in care. On the issue of age, it was noted that children under the age of 5 did not receive mental health services because the impact of the trauma was not recognized for this age group.

Concerns and issues pertaining to the access of mental health treatment already mentioned exclude one prominent group of foster youth from the outset, children who are coping well at the time of intake. Current county practices are designed to screen children for mental health service eligibility at the point of entry by their child welfare worker and, if deemed appropriate, referred for a clinical mental health screening. Even post referral additional criteria must be met before a full mental health assessment will occur for these youth. The multistep access process is in place despite that research that indicates that close to 90% of children have experienced one or more trauma exposures including physical or sexual abuse, neglect, exposure to domestic violence, community violence, or the violent death of a loved one[5]. Children who experience trauma in the form of adverse childhood experiences, which include entering foster care,

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[1] Stahmer AC, Leslie LK, Hurlburt M, Barth RP, Webb MB, Landsverk J, Zhang J. Developmental and behavioral needs and service use for young children in child welfare. Pediatrics. 2005;116:891–900

[2] Pecora, Peter S. Jensen, Lisa Hunter Romanelli, Lovie J. Jackson, Abel Ortiz. Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges, Journal of Child Welfare. 2011 Mar 21.

[3] Ibid., 1

[4] Garland AF, Hough RL, Landsverk JA, McCabe KM, Yeh M, Ganger WC, Reynolds BJ. Racial and ethnic variations in mental health care utilization among children in foster care. Children's Services: Social Policy, Research, & Practice. 2000;3:133–146

[5] Dorsey, S., Burns, B., Southerland, D., Cox, J., Wagner, H. H., & Farmer, E. (2012). Prior trauma exposure for youth in treatment foster care. Journal of Child & Family Studies, 21(5), 816-824. doi:10.1007/s10826-011-9542-4

have a well-established high risk of developing both mental health and physical health problems[6]. Hence, an explanation for the exceedingly high rates of mental health problems may be, at least in part, due to a flawed child welfare system. Current practices often deny mental health services for well-functioning youth. These children, because of their effective coping skills, may have the greatest chance for success in reunification, permanency placement, education achievement, and maintaining mental health if they receive intervention early.

Another critical issue facing foster youth who are already in treatment is psychotropic medication administration, education, and compliance. Access alone to prescribed medication can be complicated for dependency youth who need permission from a judge just to receive prescribed medications. In spite of best efforts to closely monitor compliance with prescribed medications and provide important education to youth and caregivers, gaps occur due to a shortage of medical staff and the lack of interagency communication needed to serve this special needs population. VCBH intends to address these delays and gaps in services though a systemic overhaul that will streamline and strengthen the assessment process as well as offer mental health services to all youth regardless of whether or not clinically significant behaviors are present at the time of the assessment.

Program Summary

VCBH is proposing to provide universal mental health care access for all foster youth, expedited and comprehensive assessments, and adjunct support by a medical professional for youth that receive psychotropic medication. Youth that would normally not have immediate and supportive access to mental health treatment will now have the opportunity to address the traumatic experience of removal, build resilience, and potentially, prevent the onset of mental illness. It is the assertion of VCBH that this model of expedited access, assessment, and medication support will result in the provision of appropriate mental health services early on, thus avoiding service delays and placement changes that only add to the trauma typically experienced by the youth as they enter the child welfare system.

Through the CAATS program, Ventura County plans to remodel its provision of mental health services to foster youth and families through three process improvements central to this proposal. The employment of an expedited trauma-informed assessment process performed by a team of clinicians that are specially trained to speak to all county-based services, universal mental health services for foster youth, and the employment of a Licensed Vocational Nurse (LVN) that can support the efforts to meet the psychotropic medication needs of foster youth.

First, rather than relying on case workers or a screening tool when referred, all foster youth will receive a comprehensive mental health assessment as a part of the child welfare intake process. The assessment will include the trauma-informed Children and Adolescent Needs and Strengths (CANS) -Trauma Comprehensive, a reliable and valid tool with flexible capabilities. The assessment will be conducted by clinicians specially trained to be knowledgeable in all county and community-based services and resources, streamlining the many difficulties inherent in successful interagency

[6] Pritchett,R. Hockaday,H. Anderson,B. Davidson, C. Gillberg, C. Minnis, H. Challenges of Assessing Maltreated Children Coming into Foster Care. Scientific World Journal Volume 2016, Article ID 5986835, 9 pages

collaboration. Further, this assessment will adhere to an aggressive expedited model with assessment completion and recommendations occurring within ten days of receiving the referral from Child and Family Services. This will allow for timely linkage to the appropriate services and supports for the youth and caregiver(s) thus promoting better long-term outcomes.

A second, significant change being proposed is that all foster youth will receive some level of mental health services when they enter the system. VCBH has adopted the perspective based on the Adverse Childhood Experiences research that being removed from the home is a traumatic experience that should be addressed. Accordingly, youth will be offered professional assistance in processing that loss. The modality, intensity, and duration will depend on acuity and need, but even youth identified as having only mild or moderate issues will be offered services.

A final proposed change in service delivery is the employment of a licensed medical professional to support County child psychiatrists in their difficult task of medication monitoring and support for foster youth. The licensed medical professional, with support from VCBH administration, will provide education regarding medication, better monitoring of adherence to medication, and overall improved collaboration with interagency partners. Again, the ultimate goal is improved outcomes for foster youth and families.

VCBH, along with our agency partners, feel strongly that these proposed changes in the way services are currently accessed and provided will have a significantly positive impact on the foster youth and caregiver(s) to avoid congregate care, hospitalizations, school failure, adjudication, and promote reunification/family stabilization. If the proposed changes demonstrate positive effects on the indicators mentioned above, the field of mental health would have a tested change model for how to improve service quality and outcomes for children entering the child welfare system.

Evaluation Plan

A mixed method design will be used to evaluate each of the following learning goals. Focus groups, client surveys, and assessments will all be collected in order to evaluate outcomes. Evalcorp, a third party contractor with the county, will be brought on to lead the evaluation.

<u>Research Questions/Learning Goals being considered:</u>

1. What is the level of trauma status for foster youth in the county?
2. Does an expedited assessment and service linkage process improve mental health outcomes for foster youth and caregiver(s)?
3. Does providing mental health intervention to all foster youth improve mental health outcomes? What is the level of improvement for youth experiencing mild to moderate symptoms if any?
4. Does providing a comprehensive intake assessment lead to lower rates of reentry within 12 months of reunification?
5. Does providing support, education, and oversight from an LVN lead to more accurate prescriptions and adherence to psychotropic medication?

<u>Methodology/Data Collection</u>:

All youth will be assessed with the CANS Trauma Comprehensive at intake, every 3-6 months and at discharge. Surveys will be given to youth and caregivers who received education and support from the LVN and are prescribed psychotropic medication. Focus groups will take place to review discuss and compare outcomes of the program with caregivers and clinicians of youth who would have been screened out of services under the current treatment system. Ventura County adults are assessed with the VCOS Assessment, outcomes for caregivers who are referred for services will also be tracked. The Child Welfare Indicators Project releases reentry rates for youth within 12 months of reunification annually. Reports on reentry rates, therefore, will always lag a year behind. Focus groups to take place annually with clinicians treating foster youth to discuss qualitative results of early treatment intervention.

Research Question	Indicator	Measures being considered
Question 1.	Clinical Profile	CANS –Trauma and MHSA demographics form
Question 2.	Timely Access	Tracking of service delivery through Avatar
Question 3.	Mental Health Status overall and subsection for mild to moderate youth	CANS –Trauma and psychosocial assessment. Two focus groups one with mental health providers and one with parents/caregivers of mild to moderate youth.
Question 4.	Reentry rates within 12 months of reunification	Child Welfare Indicators Project
Question 5.	Psychiatry attendance rates and reported adherence.	Surveys given to caregivers and youth. Tracking of psychiatry appointment attendance in Avatar.

Project Budget

BUDGET TOTALS	**FY 16-17**	**FY 17-18**	**FY 18-19**	**Total**
Personnel	**587,229**	**616,591**	**647,420**	**1,851,240**
Direct Costs (add lines 2, 5 and 11 from above)	**75,421**	**79,192**	**83,152**	**237,765**
Indirect Costs (add lines 3, 6 and 12 from above)				
Non-recurring costs (line 10)	**180,622**	**25,750**	**27,038**	**233,410**
Other Expenditures (line 16)	**126,491**	**108,230**	**113,641**	**348,362**
TOTAL INNOVATION BUDGET	**969,763**	**829,763**	**871,251**	**2,670,777**
TOTALS:				
Estimated TOTAL mental health expenditures for the entire duration of this INN Project by FY & the following funding sources:	**FY 17-18**	**FY 18-19**	**FY 19-20**	**Total**
Innovative MHSA Funds	534,365	457,221	480,082	1,471,668
Federal Financial Participation	435,398	372,542	391,169	1,199,109
1991 Realignment				
Behavioral Health Subaccount				
Total Proposed Expenditures	**969,763**	**829,763**	**871,251**	**2,670,777**

AGENDA ITEM 7

Action

May 25, 2017 Commission Meeting

San Diego County Innovation Projects

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of San Diego County's request to fund the following new Innovative Projects, for the duration of four (4) years and six (6) months each plan, and a funding amount (see below for project breakdown), totaling $23,780,823:

1) ***Innovation (20) Roaming Outpatient Access Mobile (ROAM)*** *- $8,788,837*
2) ***Innovation (21) Recuperative Services Treatment (ReST)*** *- $6,155,624*
3) ***Innovation (22) Medication Clinic*** *- $8,836,362*

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.

- Innovation 20, the Roaming Outpatient Access Mobile (ROAM) - proposes to purchase and develop out two mobile mental health clinics to be located in the North Inland and East County region. The mobile clinics with provide mental health services to the Native American population residing in these rural areas. The plan will include cultural brokers representing the underserved community.

- Innovation 21, the Recuperative Services Treatment (ReST) – proposes to provide respite mental health care services and housing support in an open housing development or residential site similar to Board and Care buildings for Transition-Age Youth clients with a severe mental illness (SMI) who may have a co-occurring disorder are homeless or at-risk of homelessness and are unconnected to mental health treatment.

- Innovation 22, the Medication Clinic – proposes to establish a psychiatric medication clinic at a community based organization staffed by expert child and adolescent psychiatrists, a case manager clinician, psychiatric nurses, and a program manager. The program will also provide psychoeducational groups, peer support and outreach into the community. The County also proposes establishing tele-psychiatry services at 12 regional locations.

Presenters:

- Piedad Garcia EdD, LCSW, Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (BHS).
- Alfredo Aguirre, LCSW, is the Director of Behavioral Health Services of San Diego County
- Yael Koenig, LCSW, Deputy Director for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care.
- Jeffrey Rowe, MD, Supervising Psychiatrist for the Juvenile Forensics Division of the County of San Diego Behavioral Health Services.

Enclosures (7): (1) Biographies for San Diego County Innovation Presenters, (2) Staff Summary Roaming Outpatient Access Mobile (ROAM), (3) County Brief ROAM, (4) Staff Summary Recuperative Services Treatment (ReST), (5) County Brief ReST, (6) Staff Summary Medication Clinic, (7) County Brief Medication Clinic

Handout (1): County Power Point

Additional Materials (1): Links to the County's complete Innovation Plans are available on the MHSOAC website at the following URLs:

ROAM: http://mhsoac.ca.gov/document/2017-05/san-diego-county-inn-plan-description-roaming-outpatient-access-mobile-roam

ReST: http://mhsoac.ca.gov/document/2017-05/san-diego-county-inn-plan-description-recuperative-services-treatment-rest

Med Clinic: http://mhsoac.ca.gov/document/2017-05/san-diego-county-inn-plan-description-medication-clinic

Proposed Motion: The MHSOAC approves San Diego County's Innovation Projects, as follows:

Name: Roaming Outpatient Access Mobile (ROAM)
Amount: $8,788,837
Project Length: Four (4) Years and Six (6) Months

Name: Recuperative Services Treatment (ReST)
Amount: $6,155,624
Project Length: Four (4) Years and Six (6) Months

Name: Medication Clinic
Amount: $8,836,362
Project Length: Four (4) Years and Six (6) Months

Bios for San Diego County Innovation Presenters

Piedad Garcia Ed.D., LCSW is the Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (AOABHS). Dr. Garcia oversees the mental health and substance use disorders system of care for adult and older adults across the County. She has implemented biopsychosocial rehabilitation and recovery programs for individuals with serious mental illness and co-occurring disorders. Dr. Garcia oversees the development and implementation for BHS and Primary Health Integration, the Faith-Based Initiative, the Supportive Housing and Employment Initiative, Transition Youth and Older Adult initiatives, for persons with serious mental illness and substance use disorders, BHS and justice system integration, and the integration of cultural competence standards in the mental health system.

Jeffrey Rowe, MD is the Supervising Psychiatrist for the Juvenile Forensics Division of the County of San Diego Behavioral Health Services. He has served the County in various capacities over the past 20 years including as a clinical supervisor, special evaluator for the Juvenile Court, administrator, and clinical consultant. In addition, Dr. Rowe is a Clinical Associate Professor in Psychiatry for the UCSD School of Medicine.

Yael Koenig, LCSW, is the Deputy Director for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care. She has over 20 years of experience working with children, youth and families in a variety of settings, including juvenile justice and mental health. She is responsible for overseeing over 100 contract and County operated programs with a budget of over $141 million dollars. She received her Bachelors of Arts in Social Work from Michigan State University and a Master of Social Work from the University of Tennessee. She holds a Clinical Social Worker license from the State of California.

ALFREDO AGUIRRE, LCSW

Alfredo Aguirre, LCSW, is the Director of Behavioral Health Services of San Diego County and has served in the capacity of Mental Health Director since 1999. He serves on the Board of Directors of the National Network of Social Work Managers and as a co-chair of the Cultural Competence, Equity, and Social Justice Committee of the California Mental Health Directors Association. He also serves on the Child, Adolescent and Family Branch Council, a national advisory committee to the Children's Branch of the Center for Mental Health Services under SAMHSA.

Mr. Aguirre has worked in the mental health field for over 37 years as a psychiatric social worker, staff supervisor, manager, and executive. He is the recipient of many prestigious awards, including Mental Health Person of the Year in 2008, the 2011 Hope Award for his leadership in the County of San Diego's Mental Health Stigma Reduction Media Campaign, "It's Up to Us," and the 2014 NAMI California Outstanding Mental Health Director.

STAFF INNOVATION SUMMARY— SAN DIEGO

Name of Innovative (INN) Project: INN – 20 Roaming Outpatient Access Mobile (ROAM)

Total INN Funding Requested for Project: $8,788,837

Duration of Innovation: Four (4) Years and Six (6) Months

Review History

Approved by the County Board of Supervisors: April 25, 2017

County Submitted INN Project: April 21, 2017

MHSOAC Consideration of INN Project: May 25, 2017

Project Introduction:

San Diego County proposes to develop the Roaming Outpatient Access Mobile (ROAM) program using Innovation funds. This ROAM program will focus its efforts on San Diego's Native American population with mental health issues in rural areas of the county. The plan is comprised of purchasing two fully developed mobile mental health clinics to be sent out to the North Inland region and the East County region. The County proposes the units will each have: 0.5 FTE Registered Nurse, 1.0 FTE Licensed Mental Health Clinician/Program Manager, 1.0 FTE Case Manager, 1.0 FTE Peer Support Specialist/Driver, 1.0 FTE Family Support Specialist, 1.0 FTE Administrative Support/Medical Records, and 0.5 FTE Clinician (MD and dual board certified to treat mental health and addiction). The County will use Innovation funds to build out the mobile units to include office space.

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? In addition, 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

San Diego County states their geography includes a large rural land mass with sparse populations who have barriers accessing services due to distance and culture. The populations include, but are not limited to, traditional agricultural groups, English and Spanish speakers, and Native Americans residing on tribal lands. The County states the 2012 Rural Health Status Report indicates one out of seven rural adults required help for emotional/mental problems in the past year. The County stated the 2013 Behavioral Health Community Profile indicated in rural San Diego between 2010 and 2013, 614 individuals with Schizophrenia accessed the Emergency Department (ED), 653 individuals accessed the ED for self-inflicted injuries, 297 individuals were hospitalized for self-inflicted injuries, and 69 individuals ended their life by suicide. It is not clear what percentage of these statistics represent the Native American population living in the rural areas of San Diego for the purpose of this innovation plan.

The County states the culture, history, a rural geography, trust, and engagement have been identified as barriers to mental health treatment for the Native American population. San Diego County state they aim to increase the utilization of mental health services among the Native American population by outreaching and promoting engagement in services with placing the mobile clinics on the reservations. It is not clear how much engagement the County has had with the Native American population to determine how best to address their needs and lack of utilization of services, especially, as stated by the County, they have not spoken consistently with representatives from the Native American reservations when writing the plan.

The Response

San Diego County's Innovation plan will implement two fully mobile mental health clinics in the North Inland region and the East County region, which are areas that have the highest concentration of reservation land. The ROAM program will target children and youth who have severe emotional conditions, TAY, adults, and older adults with a serious mental illness who may also have co-occurring substance use disorders, specifically in the Native American rural areas. It is not clear though if the County has confirmed these mobile clinics will be allowed onto the reservations or if they have previously engaged in conversations with the Native Americans living in the area to determine if bringing these clinics there will be received by the culture.

The County plans to include cultural brokers on each of the mobile units. The use of cultural brokering is very common in the healthcare arena and defined as the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski, 1990). A cultural broker acts as a go-between and one who advocates on behalf of another individual or group (Jezewski & Sotnik, 2001). Many cultures use these traditional healers to support reducing the stigma and discrimination experienced by underserved populations. Numerous rationales exist for the use of cultural brokers in the delivery of health care. Diverse belief systems related to health, healing, and wellness; cultural variations in the perception of illness and disease and their causes; cultural influences on help-seeking behaviors and attitudes toward health care providers; and the use of indigenous and traditional health practices among many cultural groups. San Diego

intends to utilize the cultural broker to work with the Native America populations in the set rural areas, in order to incorporate Native American culture into mental health treatment. Other counties such as Siskiyou and Trinity have used cultural brokers to help support the county mental health/behavioral health department in engaging with the population through Prevention and Early Intervention programs. Furthermore, San Diego County's first plan did not include utilizing these services to support their innovation plan. The County may wish to provide more information on how this will provide new knowledge to the mental health field and how they determined the need for cultural brokers in their plan.

According to the County's Innovation plan, "the medical field has adopted the usage of mobile clinics to facilitate access to care". A literature review conducted by Harvard Medical School (2016) indicates mobile health clinics are effective in facilitating access to health care and are considered an effective intervention for physical health needs. The same review indicates mobile health clinics are successful in providing preventative services for physical care and its ability to reach and treat underserved populations. Use of mobile units has been proven in many programs as being successful components to the healthcare arena given they allow the healthcare/mental health provider access to travel to the individuals in crisis and to provide more localized services. Increasing the mental health field is making services field-capable to reduce stigma and discrimination and to eliminate the transportation barriers faced by individuals living with mental health, and often physical health issues, preventing them from coming to a clinic for services.

The County indicates they will be utilizing newer technology to advertise their location to the Native American population given they will be changing their location often. The County has not gathered information from the reservations on their capacity to link residents to the mobile units and if they also have similar advance technology to support the residents' ability to inquire about the new services being offered by the mobile unit.

The Community Planning Process

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

The County prioritized this Innovation program based on twelve community forums and Conversation Cafes, where participants indicated that the community needed this project and suggested the addition of community members with lived experience could help make the services more acceptable and reduce stigma. Native American focus groups indicated that the culture and geography are unique factors that need to be considered in behavioral health, geographical isolation make it difficult to access services, and they identified subpopulations that would benefit from this program. The County also consulted the Older Adult, Adult and Children, Family and Youth Councils for input on the community's need for the program.

The County may wish to provide more information on how it involved the Native American population it intends to treat with this program. The County may also wish to clarify how

the idea of two mobile units were identified as a priority amongst the intended target population and the best way to increase access to services for this population.

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 states they selected this innovation project to increase access and utilization of culturally competent mental health services to Native Americans in rural San Diego communities. The County's evaluation methodology includes using client satisfactory surveys, demographic information collected on individuals who seek services from the mobile units, client's increase in understanding of mental health, attainment of education or employment, and increase in socialization. The methods of collection will be focus groups, interviews, and surveys that will be uploaded in a database program provided by University of California, San Diego's research team, used in other innovation programs at this time by the County. The County may wish to discuss other ways to improve the robustness of their evaluation.

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 County is asking for $8,788,837 for a four-and-a-half-year long project to purchase two (2) mobile units and acquire the staff for the two units.

Each mobile unit will cost $240,000 each, equaling $480,000 (or ~5.4% of the total budget). It also appears the County will incur additional operational costs to build out the mobile clinics and provide office supplies. It is unclear the total budget for the upgrades, build-out, and/or repairs and maintenance of the two mobile units. Furthermore, the County may wish to discuss their plan for the mobile units after the project ends if the project is not successful and how they will continue maintaining the mobility of the program if it is successful.

The recurring operating costs total $1,165,320 (~13% of the total Innovation budget) to support the project. It is not known what will be purchased under the operating cost. Most likely it includes the hardware, software, build out of office space and facilities in the mobile units, and office supplies.

The indirect cost totals $757,458 (9% of the total Innovation budget). It is also not clear what this money will be used for in the County's plan.

$5,990,400 (~68% of the total Innovation budget) is set aside for personnel cost. Each mobile unit will have the following staff:

- 0.5 FTE MD (dual board certified) - $225/hour
- 0.5 FTE registered nurse - $40/hour or $52,000 per year (S&B)
- 1 FTE Licensed MH clinician (dual filled as Program Manager) - $35/hour or $91,000 per year (S&B)
- 1 FTE case manager- $24 per hours or $62,400 per year (S&B)
- 1 FTE Peer Support Specialist (dual filled as driver) - $20 per hour or $52,000 per year (S&B)
- 1 FTE Family Support Specialist (dual filled as driver) - $20 per hour or $52,000 per year (S&B)
- 1 FTE cultural broker - $25 per hour or $65,000 per year (S&B)
- 1 FTE admin support/medical records - $22 per hour or $57,200 per year (S&B)

*S&B indicates salary and benefits

The evaluation budget is 4.5% ($395,658.90 total) of the budget to be contracted out to UC San Diego.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance for requirements of the MHSA.

References

"County of San Diego Transforming Behavioral Health MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17." Last modified July 26, 2013. Accessed May 12, 2017. http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf

Jezewski, M. A. (1990, August). Culture brokering in migrant farm worker health care. Western Journal of Nursing Research, 12(4), 497–513.

Jezewski, M. A., & Sotnik, P. (2001). Culture brokering: Providing culturally competent rehabilitation services to foreign-born persons. (J. Stone, Ed.). Buffalo, NY: Center for International Rehabilitation Research Information and Exchange. Retrieved May 4, 2017, from the World Wide Web: http://cirrie.buffalo.edu/monographs/cb.pdf

ROAM - Roaming Outpatient Access Mobile Services Overview

Purpose

The Roaming Outpatient Access Mobile (ROAM) Services program aims to increase access to mental health services to Native American communities in rural areas through the use of mobile mental health clinics, cultural brokers, and inclusion of traditional complimentary Native American healing practices in the treatment plan.

How

Two fully mobile mental health clinics will cover two designated regions of San Diego – North Inland and East County regions. Clinical staff per mobile mental health clinic will include clinician, nurse and dual-certified MD as well as cultural broker, peer support specialist and family support specialist. Culturally competent services will be provided to address barriers in access and utilization to services for the diverse and socio-economically disadvantaged, and underserved Native American population.

Why

In San Diego County, factors such as history, culture, geography (rural) and building meaningful and trusting relationships have been identified as barriers to accessing mental health treatment for Native American communities. San Diego proposes to increase access and utilization of culturally competent mental health services among Native American rural populations to decrease the effects of untreated mental health and co-occurring conditions.

Where

The two regions with the highest concentration of reservation land and Native American communities - North Inland and East County.

Who

The target population will be youth and Transition Age Youth (TAY) with serious emotional disturbance, families, adults, and older adults with serious mental illness of Native American descent living on the various reservations across San Diego's rural areas. Proposed number of clients served annually: 120-140 for both teams.

Innovative Components

The project adapts the pre-existing practice of Tulare County, by testing mobile mental health clinics to the unique population and geography of San Diego by focusing on Native American individuals across all age groups living on reservation land. The project will also test engagement of cultural brokers as an embedded component of treatment to evaluate its efficacy in engaging and treating local Native American members as well as evaluating the efficacy of incorporating culturally competent services and traditional healing practices in the treatment model. ROAM will include Medication Assisted Treatment (MAT) services to address individuals with co-occurring disorders.

Learning/Study Questions

- Will the use of a focused, dedicated culturally competent mental health mobile clinic improve access to and utilization for Native American communities in rural San Diego?
- Will the integration of the cultural brokers embedded within the program increase access and utilization of services and improve mental health treatment outcomes?
- Will the use of MAT services for co-occurring diagnosed clients concurrently with psychotropic medications

increase mental health outcomes among use among Native American communities in rural San Diego?
- Will the use of tele-mental health sustain engagement in treatment with clients in Native American communities in rural San Diego?

STAFF INNOVATION SUMMARY— SAN DIEGO

Name of Innovative (INN) Project: (21) Recuperative Services Treatment (ReST)

Total INN Funding Requested for Project: $6,155,624

Duration of Innovation: Four (4) Years and Six (6) Months

Review History

Approved by the County Board of Supervisors: April 25, 2017

County Submitted INN Project: April 21, 2017

MHSOAC Consideration of INN Project: May 25, 2017

Project Introduction:

The County's Recuperative Services Treatment (ReST) project will provide respite mental health care services and housing support in an open housing development or residential site similar to Board and Care buildings. The services will be for Transition Age Youth (TAY) clients with a severe mental illness (SMI) who may have a co-occurring disorder, are homeless or at-risk of homelessness, and are unconnected to mental health treatment. These clients may also have repeated utilization of inappropriate levels of care such as acute/emergency care settings and failures to connect with outpatient mental health services.

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

The Need

San Diego County reports they are experiencing a disconnect of individuals who have severe mental illness (SMI), homeless, and who utilize acute/emergency settings, but are not otherwise connected to outpatient mental health services – individuals the County considers "unconnected." Kidsdata.org states 5.5% of the teens in San Diego County

were considered “disconnected”, meaning they were not in school or working in 2015. The State average for the same year was 6.7% and 10.6% for San Bernardino County, 9.1% for Riverside County, 6.9% for LA County, and 5.1% for Orange County. The County states their Point in Time count in 2016 indicated 685 TAY who were homeless, with 459 of those TAY indicating they were unsheltered. Additionally, the count indicated that 22.8% of homeless youth had mental health issues and 14.6% had substance abuse (2016 WeALLCount).

San Diego County proposes to decrease the number of homeless and unconnected TAY to prevent these individuals from inappropriately returning to acute/emergency mental health services by providing them with recuperative mental health care in a centralized home-bound program.The County also noted that, among these individuals, there has been repeated inappropriate utilization of these acute/emergency mental health services due in part to being unconnected to outpatient mental health services. The County may wish to share if they considered SB82/Triage grant funds to provide crisis intervention and diversion services to the homeless TAY to help reduce their use of acute/emergency mental health services.

The Response

San Diego County’s Innovation plan proposes to develop a recuperative-care site that will be a “home-like” environment in design with a live-in resident manager and cook. The County intends to develop office space to co-locate the following staff on-site: a program manager, housing specialist, licensed mental health clinician, case manager with AOD certification, peer support specialists, nurse practitioner, and a part-time psychiatrist to co-locate to provide mental health services. The program will provide screening, behavioral health assessment, individual and group counseling, medication management, case management, care coordination, peer and family support services, linkages to permanent housing and other needed resources. Medication Assisted Treatment (MAT) services will be available for individuals with a co-occurring substance use disorder. The County seeks to use their peer specialists to provide habilitation services and support the TAY residents. Habilitation refers to a process aimed at helping disabled people attain, keep or improve skills and functioning for daily living. The County anticipants servicing 15-17 TAY individuals at any given time with each resident staying anywhere from 60-90 days. It is unclear how the multidisciplinary team will support the TAY developing vocational skills needed to sustain long-term stable housing upon discharge from this respite home.

Research shows that recuperative care centers for the homeless are very common. Santa Cruz County has implemented through an innovation, the Recuperative Care Center Shelter (RCCS) that receives homeless individuals discharged from inpatient stay at their local hospitals in order for a medical recovery while also receiving integrated social services, including housing, mental health services, benefits enrollment, and substance abuse treatment. The RCCS will take youth over the age of 18 years old, upon referral. It appears similar to what San Diego proposes with the exception of being referral based.

San Diego County indicated they are aware of many recuperative care centers around the United States. The County researched the Restart Program in Arizona aimed at providing short-term housing only to individuals with SMI that are transitioning from

hospitals and/or jails back into the community. Upon further review, it seems the Restart Program has peer recovery coaches, behavioral health technicians, counselors and team leads supporting their clientele in finding longer term housing, either through reconnection with family, Supportive Community Housing, or preparation for a treatment-oriented housing setting. The Restart Program also provides habilitation services through wellness group and 1:1 support to learn living skills, link clients to transportation, support the development of personal care, and ways to set medication reminders.

The 2015 National Health Care for the Homeless Council, Inc. also reports a comprehensive list of respite models embedded in the healthcare and mental health community throughout the nation. It is not clear if San Diego reviewed to see if any of these programs provided the same habitable conditions this innovation project proposes to do with their "home-like" environment. Furthermore, it is not clear how the County will be able to obtain the required licenses for a residential facility given the residents are unrelated TAY (age 16-25 year olds) persons living together. The County may wish to share details on the type of facility they intend to lease for this project.

The County states ReST will be an "Enhanced Strength Based Case Management" program. This is a known best practice in the recovery-based service model. It reflects providing case management based on the client's strengths and self-determination to lead to more sustained acceptance for change. The practice has shown positive results for youth to older adults, living with mental illness or a substance abuse disorder, in school settings and in the community. The County may wish to share more detail on how using this approach will bring new learning and knowledge to the mental health field.

The Community Planning Process

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

The County reports it conducted 12 community forums to get community feedback and soliciting input from the Older Adult, Adult and Children, Family and Youth Councils. It appears the County developed the ideas and provided opportunities to the community to discuss the project and provide feedback. The County does not, however discuss the feedback nor provide a clear path as to how the idea was first formulated. This community program planning process does not appear to have come out of a ground swell of need, or community support or buy in and does not indicate how the CPP process was utilized in the development of either the plan elements or the budget process. The County was apprised during the technical assistance call of this shortcoming and may be adding clarifying information as to its CPP 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 has brought forth a project with well thought out learning objectives with the potential of leading to interesting outcomes; however the methodology does not match the robustness of their learning objectives. The County is proposing to use focus groups, and recidivism data, and then allowing University of San Diego research team to develop and analyze their collected data. The County may wish to develop a more comprehensive evaluation process, and data collection process.

The Budget

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

The total operating cost to support the project is $2,768,310 (~45% of the total Innovation budget). The County only states the will use $1,620,000 for a master lease on 20 units (~23% of the total budget or $18,000 per unit per year/$1,500 per unit per month rent) and $75,000 to provide food to clients (at the rate of $15.8 /day). The remaining operating cost of $1,0733,310 will be used for flex funds, maintenance, utilities, supplies, and transportation. There is no additional detail on the remaining part of the operating cost budget. Furthermore, the County indicates the operating cost budget was calculated at 30% of salary and benefits. Typical budgets allow for 15% operating costs to be added onto personnel salary and benefits. They did not adjust this budget after the TA call indicating this was a higher calculation rate then typically seen in budgets.

The County may wish to provide a per TAY resident cost for this program given they anticipate serving 15-17 individuals at any given time. The evaluation budget is 5% ($291,877.33 total) of the budget.

$2,889,900 (~47% of the total Innovation budget) is set aside for personnel cost for:

- 1 Program Manager - $33/hour $85.800 per year (S&B)
- 1 Housing Specialist - $22/hour $57,200 per year (S&B)
- 1 FTE Nurse Practitioner - $59/hour $76,700 per year (S&B)
- 1 FTE Licensed Clinician - $$27/hour $70,200 per year (S&B)
- 1 FTE Case manager- $24/hour $62,400 per year (S&B)
- 2 FTE Peer Specialists- $18/hour $46,800 per year (S&B)
- 1 Admin/Medical Records - $20/hour $52,000 per year (S&B)
- 1 Cook - $15/hour $39,000 per year (S&B)
- 1 Live-In Housing Manager - $24.50/hour $63,700 per year (S&B)
- 1 Psychiatric Consult - $200/hour $41,600 per year (Salary only)

Additional Regulatory Requirements

The proposed project appears to meet minimum standards for compliance for requirements of the MHSA though the plan provides limited details on the budget and evaluation plan.

References

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ReST - Recuperative Services Treatment Housing Overview

Purpose
San Diego County proposes to decrease the number of homeless and unconnected Transitional Age Youth (TAY; 18-25y/o) with severe mental illness (SMI) to prevent these individuals from inappropriately returning to acute, emergency mental health services (e.g. hospitals, emergency departments, crisis homes, Psychiatric Emergency Response Team, and jail mental health services) by providing recuperative and habilitative mental health care support to these individuals in respite housing. Participation in ReST is up to 90 days.

How
The Recuperative Services Treatment (ReST) Housing program is designed to provide respite mental health care services and housing support in an open housing development or residential site for TAY clients with SMI. Individuals will be referred post-discharge from acute, emergency mental health services. Those enrolled in the program will be engaged in recuperative services and connected to appropriate levels of care and housing to support ongoing recovery and wellness. ReST will be an Enhanced Strength Based Case Management program with mental health services.

Why
San Diego's number of homeless TAY increased from 685 to 1082 between 2016 and 2017 (WeALLCount). Among individuals who have accessed emergency mental health services (e.g. hospitals, crisis homes, Psychiatric Emergency Response Team (PERT), or jail services), not all individuals are connected to outpatient mental health service providers; these individuals are considered "unconnected." In Fiscal Year 15/16, there were 196 unconnected homeless TAY that accessed emergency mental health services in San Diego County. These clients also have repeated utilization of inappropriate levels of care such as acute care hospitals, jails, emergency departments and failure to connect with outpatient mental health services or most appropriate level of care.

Where
The recuperative-care site will be a "home-like" environment with co-located mental health services.

Who
TAY (18-25 years old) clients with severe mental illness (SMI) who: 1) require habilitative services (e.g. managing symptoms, learning activities of daily living) post-discharge from acute care settings; 2) are homeless or at-risk of homelessness; 3) are unconnected to mental health treatment; and 4) have repeated utilization of inappropriate levels of care (e.g. acute/emergency care settings or jail in-patient care). Proposed number of clients served annually: 48-60.

Innovative Components
ReST is an adaptation from the medical field's recuperative care centers that have been shown to reduce readmission to acute care settings. The services provided through ReST are geared towards providing a different experience with mental health providers and to engage and connect the TAY clients to ongoing appropriate levels of care, link them to housing, reduce stigma associated with using mental health services and provide TAY with skills (e.g. managing symptoms, activities of daily living, educational or employment skills) so that they will decrease inappropriate use of acute, emergency care settings or jail. Additionally, there will also be a "mentorship" component in which Peer Support Specialists will continue to work with clients after they have left ReST to ensure continuity and provide support 30-60 days post-completion of ReST.

May 25, 2017

Learning/Study Questions

- Does the use of respite care and habilitation model demonstrate success in penetration and retention of TAY who are unconnected to treatment and have repeatedly utilize acute care, crisis residential treatment, EDs, PERT and jail mental health services?
- Did TAY enrolled in ReST demonstrate an improvement of their symptoms or mental health condition?
- Did TAY enrolled in ReST demonstrate an increase in engagement with treatment due to the provision of housing and co-location of mental health and support services?
- Does ReST impact acute/emergency care (Crisis Residential Treatment, ED, PERT, EPU, and jail mental health services) recidivism?
- Do TAY enrolled in ReST demonstrate an ability to stay connected to treatment during and post discharge?
- Do TAY enrolled in ReST demonstrate a reduction of stigma associated with their symptoms or mental health condition?
- Do TAY enrolled in ReST demonstrate an increase in knowledge of how to access behavioral health services and housing supports?

STAFF INNOVATION SUMMARY — SAN DIEGO COUNTY

Name of Innovative (INN) Project: Medication Clinic

Total INN Funding Requested for Project: $8,836,362

Duration of Innovative Project: Four and a half (4.5) Years

Review History

Approved by the County Board of Supervisors: April 25, 2017
County Submitted Innovation (INN) Project: April 21, 2017
MHSOAC Consideration of INN Project: May 25, 2017

Project Introduction:

San Diego County proposes using Innovation funds to establish a psychiatric medication clinic at a community based organization and staffed by expert child and adolescent psychiatrists, a case manager clinician, psychiatric nurses, and a program manager. The program will also provide psychoeducational groups, peer support and outreach into the community. In addition, the county proposes to establish tele-psychiatry services in 12 regional locations throughout the County.

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

San Diego County reports there are approximately 75,000 children and youth at risk for mental health problems. Its Behavioral Health Services division serves approximately 18,000 children and youth per year. Currently, its treatment model for these children/youth is 13 therapy sessions per child/youth with the option of an additional cycle of 13 sessions dependent upon a utilization review. The child/youth can only receive medication support if they are linked to therapeutic services. San Diego County reports it currently has a type

of continuum of care for these children/youth (and in some cases, their families), and indicates that this model, based upon the Child Guidance Clinic model, works well for those children/youth who are responsive to medication, do not require long-term treatment or do not have co-morbid issues such as physical issues which might complicate their care. This system does not currently treat children/youth seen by primary or specialty care doctors and who might also have co-morbid emotional issues or require medication for psychiatric issues, or who do not necessarily have access to the continuum of care provided by County Behavioral Health Services. Furthermore, the County reports having a shortage of child/adolescent psychiatrists who take Medi-Cal and see children in their private practice. This is a shortage experienced throughout the state.

The County does have a Smart Care program which provides telephone consultation to primary care physicians who encounter children/youth with mental health problems. It is currently staffed with one child and adolescent psychiatrist. This program, however, is not currently designed to provide either long term consultation or consultation for complex co-morbid issues. The medical professional also provides consultation to the primary care doctor and may not always see the child in person to determine the best course of care. The County indicates extensive literature searches, focus groups and interviews with professional staff and organizations led to the development of the Smart Care program, however even this program is not sufficient to handle the complex needs of the population they are proposing to serve through this Innovation project.

Although the County indicates this program expects to serve 500 children/youth per year, it does not provide any information regarding the number of children/youth who are currently not being served or who have profound co-morbid, or complex medical and psychiatric and/or mutually interfering diagnoses, or potentially complicated treatment protocols. It would be helpful to get a benchmark from the County on the need for this level of services in the county's continuum of care.

The Response

San Diego County proposes to establish a medication clinic staffed by child/youth experts in the field of psychiatry. These staff will provide support vis a vis multiple settings; 12 tele-psychiatry sites, on site psychiatry at a specialty medical office (for Developmental or Behavioral pediatricians) and an on-site office based psychiatric care for medication support at a centrally located facility in the County. In addition, the County indicates they expect to provide psychoeducational presentation about mental health problems, treatments, resources, and medication side effects. The program intends to provide resources to families, linkage to peer support groups, consultation to schools, probation staff and other primary care offices.

Staff research of literature on best practices, as well as the concept of medication clinics, identified that majority of the materials and programs are designed for adults, adults with substance use issues, or justice involved youth. This may be as a result of few programs seeking to maintain children on medication support and the State of California turning to evidence-based practices to treat the mental health needs of children rather than utilizing medications. The County may wish to discuss further their rationale to use ongoing medication support rather than other auxiliary services as suggested by best practices for children and youth with severe emotional disturbances.

There are a couple of examples of integrated behavioral and physical health programs for children. Specifically, Children's Hospital of Orange County (CHOC), has an outpatient clinic for young children whose physical conditions, such as diabetes, cancer or epilepsy are complicated by mental health challenges. Since it was established in 2015, there is little information available about the efficacy of the program. It is not clear if San Diego County has spoken to their neighboring County to discuss the efficacy of this program. Golden Valley Health Centers, located throughout central California, also provides co-located services for children/youth and was cited as a promising Medicaid model by the Kaiser Family Foundation. San Diego may wish to further discuss how their program will bring new knowledge to the mental health field for child psychiatry.

What is available, however, are a number of papers and studies regarding successful elements of integrated programs serving both mental and physical health programs. Again, because the body of literature describes programs working primarily with adults, it would be difficult to make assumptions that the elements of those programs are completely transferrable to a children's clinic, however the San Diego proposal appears to incorporate some of the identified best practices. It appears as though the County is adapting the best practices for adults for their children population.

The County intends on continuing the medication clinic through EPSDT Medi-Cal and Federal Participation funds. They may wish to explain the reasons to not expand the Smart Care program at this time with the same funding sources given the effects of continuing medication support for these children is established as a positive outcome.

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 it conducted 12 community forums to get community feedback and soliciting input from the Older Adult, Adult and Children, Family and Youth Councils. It appears the County developed the ideas and provided opportunities to the community to discuss the project and provide feedback. The County does not, however discuss the feedback nor provide a clear path as to how the idea was first formulated. This community program planning process does not appear to have come out of a ground swell of need, or community support or buy in and does not indicate how the CPP process was utilized in the development of either the plan elements or the budget process. The County was apprised during the technical assistance call of this shortcoming and may be adding clarifying information as to its CPP 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.

Although the County proposes some interesting project related questions it hopes to answer; the method for evaluating the project and/or answering its questions is not developed. Instead, the County proposes that evaluators from the University of San Diego will assist with the development of measures along with data collection and analysis. Additionally, the County proposes to develop a questionnaire to help with identifying health outcomes goals for each child served in the clinic and a follow-up questionnaire to be developed to ascertain if the child met their goals. Unfortunately, neither this last data collection methodology nor the unknown contribution from the university as to what they will develop adequately address many of the evaluation questions, proposed by the County, i.e. “can we potentiate the stability of youth by providing consistent, long-term relationships with the prescriber team”. The County has been advised of this concern and may wish to discuss ideas to enhance their evaluation process to provide new knowledge to the mental health field, particularly child psychiatry.

The Budget

This section should address 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 approval of $8,836,362 for four and a half years (4.5 years).

The County’s original budget requested a total of $5,007,600 (or 57% of the total budget) for personnel costs. The County’s original plan was to hire the following positions at the salaries listed below. Their new budget, submitted on 5/11/17 increased the personnel budget to $6,303,960 per year (71% of the total budget) and does not include details of their roles, full-time equivalent (FTE), or rational for the $1,300,000 increase in personnel costs. The County may wish to provide more information on the increase in this budget and whether this information was made available during the local approval process.

> 2.0 Psychiatrists (presumably with a child/adolescent specialty)- $175 per hour or $364,000 per year
>
> 1.0 FTE Psych Nurse- $50 per hour or $130,000 per year (S&B)
>
> 1.0 FTE Program Manager- $40 per hour or $104,000 per year (S&B)
>
> 1.0 FTE Licensed Mental Health Professional- $38 per hour or $98,800 per year (S&B)
>
> 1.0 FTE Admin Associate- $20 per hour or $52,000 per year (S&B)
>
> *S&B stands for salary and benefits.

The County originally asked for $1,502,280 (17% of the total budget) for operating costs; which includes rent, business expenses, cost of medication, and equipment. The County indicates the operating cost budget was calculated at 30% of salary and benefits. Typical budgets allow for 15% operating costs to be added onto personnel salary and benefits. The County addressed this issue in their revised budget forwarded on 5/11/17 by decreasing the total budget for operating costs to $1,295,312 (15% of the total budget) but did not share the new percentage used for calculating. It appears they increased the base salary by $300,000 to lower the percent calculated. It is difficult to determine how this change came about due to the lack of clarification on how they transferred money from operating costs and indirect costs over to an increased personnel costs.

It is also unclear what falls under the indirect cost, which total $976,482 (11% of the total budget).

The County will contract with UC San Diego and has dedicated $450,000 (5% of the total budget) to evaluation. The County placed this budget under operating costs, while other counties list this under contractors or evaluation.

Apart from providing staff titles and hourly pay rates, the County does not provide a budget narrative as to FTE's, differentiation between medication costs, business expense costs or even rent (i.e. prorated share of costs) for any of the facilities being utilized in implementation and operation of this project. This type of detail could be helpful and address some of the disproportionality identified in the salary section.

Additional Regulatory Requirements

The proposed project does not meet the minimum regulatory requirements as stated in MHSA Innovation regulations insofar as it does not provide a clear evaluation process, a budget narrative, and a project timeline. The County may wish to discuss further the reason to not include this information in the plan presented to the public, local mental health board, Board of Supervisor, and the MHSOAC.

References

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Medication Clinic Overview

Purposes

1) To provide accessible medication support services to children and youth with complex needs who have completed psychotherapy services but continue to require psychotropic medications to sustain their functioning, so that they can participate in school, community activities, and in a rich home life.
2) To provide psychotropic medication support services to children and youth with complicated medical problems in their pediatric care setting.
3) To provide psychoeducational support services to caregivers regarding psychiatric diagnosis, medication treatments, and other resources that can support treatment of children and youth with complex mental health needs.

How

Create a Psychotropic Medication Clinic staffed by expert Child and Adolescent Psychiatrists, Case Manager, Clinicians, Psychiatric Nurse, and a Program manager. Prescribers will provide medication support services via traditional face-to-face office visits, tele-psychiatry, as well as be embedded in Developmental Behavioral Pediatrician offices. Create a Center of Excellence for families to obtain education and support.

Why

For select youth, continuing psychotropic medications is essential to a stable and sustainable wellness, but resources for medication management only services are limited. Youth with complex psychotropic medication regimens present an even greater challenge for access to services. Recent legislative changes have focused on the importance of careful oversight for the provision of psychotropic medications for Medi-Cal youth; a dedicated medication clinic will carefully monitor and implement legislative changes.

Where

1) In a centrally located psychiatric clinic for direct services and the psychoeducational services;
2) In a Special Needs Pediatric Clinic and a Developmental Behavioral Pediatric Clinic; and
3) In conjunction with primary care medical offices or other diverse locations, the project intends to staff 2 locations per region (total of 12 sites) via tele-psychiatry.

Who

1) Children and youth with serious emotional disturbances who are stable and have completed their psychotherapy treatment services;
2) Children and youth who are new to San Diego County and are awaiting entry into outpatient programs and are already taking psychotropic medications; and
3) Children and youth, who are currently being treated for complex medical problems and have serious mental health problems, but have no access to a child and adolescent psychiatrist.
Proposed Clients Served Annually: 510

Innovative Components

Clinic intends to provide psychiatry services via a variety of modalities (including tele-psychiatry) to support youth who require complex psychotropic medication regimens on an ongoing basis to maintain stability. There will be a focus on

youth prescribed complex medication regimens which, given recent legislative changes, has been increasingly critical to closely monitor. The Medication Clinic will offer on-site collaboration, psychiatric evaluations and treatment in pediatrics offices that serve medically complex youth, a population identified to be under-served both locally and nationwide. Create a Center of Excellence to support caregivers.

Learning/Study Questions

- Will stability of children and youth improve through long-term medication support?
- Does acceptability of having a psychiatrist in a Pediatric clinic as part of the clinical team (to the pediatrician, the staff, the children, and the families)?
- What does it take to support the working relationships, communication efforts, safety and integration of care, improvement of health outcomes?
- Can a Center of Excellence in Psychiatry be seen by its users as a helpful support (children, families, organization that consult with the Center)?

AGENDA ITEM 8

Action

May 25, 2017, Commission Meeting

Request for Funding for Evaluation and Transparency Portal Projects

Summary: The Commission will consider authorizing the Executive Director to enter into a contract to support the development of a statewide survey of the mental health needs and unmet needs of transition age youth (TAY). Fred Molitor, Director of Research and Evaluation, will discuss a draft outline of the proposed scope of work.

The Commission will also consider authorizing the Executive Director to enter into contracts to further support the program evaluation and data transparency needs of the Commission, including the implementation of a pilot classification study of Full Service Partnership programs, and ongoing maintenance of the MHSOAC website and data portal environments. Deputy Director for Evaluation and Program Operations Brian R. Sala, will provide a brief update regarding the project and discuss a draft outline of the proposed work.

Presenters:
Fred Molitor, Ph.D., MHSOAC Director of Research and Evaluation
Brian R. Sala, Ph.D., MHSOAC Deputy Director for Evaluation and Program Operations

Enclosures: Summary of Proposed TAY Study

Handouts: A PowerPoint slide show will be presented at the meeting.

Proposed Motion: The MHSOAC authorizes the Executive Director to enter into contracts for an amount not to exceed $720,000 as follows:

- Not to exceed $200,000 to support the development of a statewide survey of the mental health needs and unmet needs of transition age youth;
- Not to exceed $225,000 to support a pilot classification study of Full Service Partnerships in selected counties;
- Not to exceed $50,000 to support technical testing activities related to the Transparency Data Portal projects; and
- Not to exceed $245,000 for ongoing maintenance of the MHSOAC website, ongoing maintenance and operations of the Transparency Data Portal environment, and ongoing maintenance and operations of the MHSOAC data warehouse and analytical environment.

Assessing Levels of Mental Health Need and Unmet Need among Transition Age Youth
May 16, 2017
Fred Molitor, PhD

Objectives
To estimate levels of mental health need across general and/or within selected transition age youth (TAY) subpopulations such as lesbian, gay, bisexual, transgender and queer (LGBTQ) or those coming of age in foster care or jails, overall and across racial/ethnic and other groups. To assess levels of unmet need across the continuum of mental health services, from treatment for severe mental illness through those services provided through Prevention and Early Intervention (PEI) programs.

Background & Rationale
Half of all mental health disorders begin before the age of 14 years.[1] The median age of onset for many disorders occurs during the transition phase to adulthood, these include obsessive-compulsive disorder, substance use disorders, agoraphobia, post-traumatic stress disorder, panic disorder, and bipolar disorder.[1] The National Comorbidity Survey-Adolescent Supplement (NCS-A), a nationally representative survey, found that 22.2% of 13 to 18 year olds met the criteria for a mental disorder with severe role impairment and distress.[2] Whites, Latinos, and African Americans have similar rates of mental health needs,[3] but disparities exist in terms of receipt of services. African American and Latino young adults access mental health services at less than half the rate of Non-Hispanic White young adults.[3]

A Mental Health Services Act (MHSA) directive requires counties to provide services to address the needs of those 16 to 25 years old, referred to as transition age youth (TAY). The term TAY is used to describe in general terms those aged 16 to 25 years, and specific subpopulations of pre and young adults who are at greater risk of mental health disorders, such as those who age out of the foster care system.[4] Former foster youth are more likely to be homeless, unemployed, and 10 times more likely to be arrested than youth of the same age.[5] One in four youth who age out of foster care are incarcerated within the first two years of leaving care.[5]

In addition to foster youth, there are several very important at-risk TAY subpopulations for whom the assessment of levels of mental health needs and the degree to which these needs are being met is important. These subpopulations include:

- Incarcerated youth who may be getting services in jail or juvenile hall;
- Young military personnel who may have some needs met through their service;
- Students who may have some needs met through student services; and
- LGBTQ TAYs.

Previous studies attempting to estimate levels of mental health need have focused mostly on adults and only on severe mental health disorders (serious emotional disturbance or serious mental illness).[6,7] High benchmarks have also been set for operationalizing levels of met need (and conversely levels of unmet need). For example, in one study, met need was defined as having four or more visits with a health professional in the past 12 months and use of

prescription medications for mental health problems during this same period of time.[7] The utility of published rates of unmet need from the National Survey on Drug Use and Health is limited. This is because need met through mental health services is too broadly defined (i.e., questions about mental health services received do not ask about specific treatments for specific disorders), and the survey instrument does not fully represent unmet need for those services available through PEI and other MHSA enhancements.[8]

PEI activities and services are designed to provide an early response to emerging needs before they become severe and disabling. PEI programs offer a variety of non-clinical services, as required by the MHSA, such as outreach and referrals. Pre and young adults are an important population for targeting PEI services since their mental health needs are more likely to be in the early stages; that is, have not progressed to a point where such PEI services would not be as effective or are inappropriate. The investment in PEI is substantial; each year over $350 million MHSA funds support services to prevent or intervene before disorders progress in severity. Yet, the extent to which these services reach selected populations, including TAYs, has not been documented.

An initial review of the literature shows a lack of adequate measures for assessing the needs and unmet needs of TAYs, particularly for establishing population-based estimates for TAYs or special subpopulations. For example, child and TAY specific measures, like the Child and Adolescent Needs and Strengths (CANS)[9] and Adult Needs and Strengths Assessment – Transition to Adulthood Version (ANSA-T),[10] are generally used for the assessment of needs and strengths to inform treatment planning. Inferences about the level of need met are made indirectly via accessing additional information on services delivered or by comparing changes in item scores over a period of time.[11.12] Other measures, which assess need and unmet directly, like the widely-used Camberwell Assessment of Need (CAN),[13] focus predominantly on adults with severe mental illness, and do not necessarily capture the needs of young people and the range of services provided under the MHSA, in particular PEI services.

An assessment of the levels of mental health needs and unmet needs through a population-based statewide survey or within specific subpopulations of TAYs using non-probability sampling techniques could provide the MHSOAC and counties across California with information to inform program planning decisions and potentially placing greater emphasis on PEI and other services directed at TAYs.

For a population-based survey, the sampling frame could be the Medi-Cal Eligibility Data System (MEDS) from the Department of Healthcare Services (DHCS), which consists of eligibility information of beneficiaries for Medi-Cal and other public programs such as CalWORKs and CalFresh. Information in the MEDS is entered at the household-level, and is quite detailed: the full name, gender, age, race ethnicity, and primary language for all family members are available. Contact information includes the complete mailing address and phone numbers; in some cases more than one phone number is available and can include the cell numbers for all persons 18 years of age and older. As such, MEDS represents an ideal sampling frame for this

proposed study in terms of the detailed information available to facilitate recruitment of persons within households that are more likely to rely on county mental health services.

The sampling unit will be the household, stratified by age (minors ages 16 and 17 versus 18 to 25 year olds) and race/ethnicity (over-sample of Latinos and African Americans). Within households with more than one member from the target population, one minor or young adult will be selected via a random process. Recruitment procedures will include mailing letters of introduction to the households before telephone contact. The letters will be addressed to the parent/caregiver for households with minors, and addressed by name to those 18 through 25 years of age. Telephone recruitment procedures will also differ by household type, with parent consent and then assent obtained from households with minors and verbal consent obtained directly from adult survey participants. For households with 18 to 25 year olds, a standardized script will be developed and presented to parents/caregivers reached during initial telephone calls to request contact information, as needed, from the target adult survey respondents.

The MHSOAC could support both developing and implementing a large-scale survey that would include TAY recruited using the MEDS as a sampling frame and the selection of TAY in jails or group homes through cluster or convenience sampling. Whether MHSA resources to investigate levels of needs and unmet need should support a general population survey or are best directed at a subpopulation of at-risk TAYs, such as those formerly in foster care, requires additional investigation and would benefit from the recommendations of researchers and stakeholders. A workgroup of subject matter experts will assist in developing a survey instrument and refining the survey methodology, including stakeholders such as:

- Client advocates TAYs
- TAY researchers and subject matter experts
- Child welfare (foster care) experts
- Juvenile justice experts
- Large scale survey experts

Project Phases

A three-phase process is proposed for an unmet need study of TAYs. Funding for Phase 1 would support identifying the target study population(s), refinement of the survey methodology, and questionnaire development and based on the recommendations of researchers and stakeholder and a more extensive literature review on TAYs with mental health needs and how these needs are (not) being met, with a particular focus on studies conducted in California after the implementation of the MHSA (Table).

Focus groups with general population TAYs and TAYs from special populations (such as young people in foster homes or jail settings) will help inform survey development. Stakeholder recommendations on the survey methodology will include whether the instrument will be self-administered or interview based. Cognitive interviewing will be conducted on a draft of the questionnaire that will be administered to a sample of TAYs and other stakeholders, ensuring that items are comprehensible and that the intended information is being collected. Sample sizes will be calculated to optimize the inclusiveness and generalizability of the data collected.

Table: Proposed Project Phases

Project Phase	Description	Deliverable
1	Identification of Target TAY Population(s) Refinement of Methodology Development of Survey Instrument SOW to include: • Expand literature review • Form and facilitate workgroup meetings with researchers and stakeholders • Focus groups • Questionnaire development • Cognitive interviewing and piloting the survey instrument • Calculation of sample size	Research Plan with Literature Review and Proposed Methodology Survey Instrument
2	Survey Data Collection Survey Vendor SOW to include: • Formatting questionnaires for telephone and possibly web-based survey • Sampling • Training of interviewers • Recruitment and conducting interviews • Distribute incentives	Cleaned database
3	Data Analysis and Reporting Data Analysis and Develop Reports and Publications with Assistance in Interpreting Survey Findings by Stakeholders	Reports and Publication

Phase 2 of the project could include a general population and/or selected population survey approaches. Phase 3 would include analyses and reporting of the survey data and reports and publications with stakeholders' assistance in interpreting the findings. A request to the Commission to support Phases 2 and 3 would be made at the completion of Phase 1.

It is important to note that the utility of the deliverables of Phase 1, the TAY survey instrument and literature review, are valuable independent of any subsequent project phases. For example, the questionnaire could be used by programs and counties across California as an evaluation tool for assessing the needs of their local TAY populations.

Successful implementation of Phases 2 and 3, if justified, could lead to ongoing cross-sectional surveys to estimate levels of need and unmet need among the same population to assess changes over time, or within different populations such as children or adults. Moreover, behavioral health departments could be invited to cover the increased costs of oversampling within their jurisdictions to obtain statistically-stable county-level estimates for local program planning and evaluation purposes.

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AGENDA ITEM 9

Information

May 25, 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: (1) Motions summary from the April 27, 2017 Commission Meeting; (2) Evaluation Dashboard Summary; (3) Evaluation Dashboard; (4) Evaluation Snapshot of Contract Deliverables; (5) Calendar of Commission activities; and (6) Innovation Review Outline.

Handout: None

Recommended Action: Information item only

Motions Summary

Commission Meeting
April 27, 2017

Motion #: 1
Date: April 27, 2017
Time: 9:29 AM

Text of Motion:

The Commission approves the March 23, 2017 Meeting Minutes.

Commissioner making motion: Boyd
Commissioner seconding motion: Buck

Motion carried 9 yes, 0 no, and 1 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

Motion #: 2
Date: April 27, 2017

Time: 9:39 AM

Text of Motion: The Commission supports Assembly Bill 1315 (Mullin).

Commissioner making motion: Boyd
Commissioner seconding motion: Van Horn

Motion carried 11 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

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

Motion #: 3
Date: April 27, 2017

Time: 9:46 AM

Text of Motion: The Commission supports Assembly Bill 254 (Thurmond).

Commissioner making motion: Boyd
Commissioner seconding motion: Aslami-Tamplen

Motion carried 11 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

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

Motion #: 4
Date: April 27, 2017

Time: 10:15 AM

Text of Motion: The Commission supports Senate Bill 191 (Beall).

Commissioner making motion: Boyd
Commissioner seconding motion: Van Horn

Motion carried 10 yes, 0 no, and 1 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	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

Motion #: 5
Date: April 27, 2017

Time: 12:11 PM

Text of Motion:

The Commission adopts the report, *Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities*, with the change to Recommendation #4 to preserve the reverted funds to the MHSA component from which they reverted.

Commissioner making motion: Buck
Commissioner seconding motion: Boyd

Motion carried 11 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

Motion #: 6
Date: April 27, 2017

Time: 12:27 PM

Text of Motion:

The Commission supports Senate Bill 192 (Beall).

Commissioner making motion: Anthony
Commissioner seconding motion: Boyd

Motion carried 10 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motion #: 7
Date: April 27, 2017

Time: 2:28 PM

Text of 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

Commissioner making motion: Gordon
Commissioner seconding motion: Aslami-Tamplen

Motion carried 10 yes, 0 no, and 1 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 #: 8
Date: April 27, 2017

Time: 3:08 PM

Text of Motion:

Pending Kern County's Board of Supervisors approval, the MHSOAC approves Kern County's Innovation Project, as follows:

Name: Special Needs Registry Smart 911
Amount: $3,170,514
Project Length: Five (5) Years

Commissioner making motion: Van Horn
Commissioner seconding motion: Buck

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

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motion #: 9
Date: April 27, 2017

Time: 3:19 PM

Text of Motion:

The Commission approves the contracts 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 contracts for up to $500,000.

Commissioner making motion: Boyd
Commissioner seconding motion: Wooton

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

Name	Yes	No	Abstain
16. Chair Wooton	☒	☐	☐
17. Vice-Chair Boyd	☒	☐	☐
18. Commissioner Anthony	☒	☐	☐
19. Commissioner Ashbeck	☐	☐	☐
20. Commissioner Aslami-Tamplen	☐	☐	☐
21. Commissioner Beall	☐	☐	☐
22. Commissioner Brown	☐	☐	☐
23. Commissioner Buck	☒	☐	☐
24. Commissioner Danovitch	☒	☐	☐
25. Commissioner Gordon	☒	☐	☐
26. Commissioner Lynch	☒	☐	☐
27. Commissioner Mitchell	☒	☐	☐
28. Commissioner Poaster	☐	☐	☐
29. Commissioner Thurmond	☐	☐	☐
30. Commissioner Van Horn	☒	☐	☐

MHSOAC Evaluation Dashboard Summary

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

Changes/Updates:

External Evaluation Contracts

- **Full Service Partnership (FSP) Classification Project** *Mental Health Data Alliance*
  Update: Deliverable 9 is now due May 31, 2017.

- **Recovery Orientation of Programs Evaluation** *The Regents of the Univ. of California, University of California, San Diego*
  Update: All the deliverables are now complete.

- **Early Psychosis Evaluation** *The Regents of the Univ. of California, University of California, Davis*
  Update: Deliverable 6 is under review. Deliverable 7 is now due on June 1, 2017.

- **Assessment of System of Care for Older Adults** *The Regents of the Univ. of California, University of California, Los Angeles*
  Update: Deliverable 4 is now due May 30, 2017. Deliverable 5 is now due August 7, 2017.

- **Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit** *The Regents of the Univ. of California, University of California, San Diego*
  Update: Deliverable 3 is completed.

MHSOAC Evaluation Dashboard March 2017

(updated 5/17/17)

Mental Health Services Oversight & Accountability Commission

Current MHSOAC Evaluation Contracts and Deliverables

Mental Health Data Alliance (MHDATA)				
Full Service Partnership (FSP) Classification Project (14MHSOAC008)				
MHSOAC Staff: Brian Sala **Active Dates**: November 2014 – June 30, 2017 **Objective:** The original purpose of this evaluation effort was to classify Full Service Partnerships (FSPs) in a meaningful and useful fashion on a statewide level to support statewide assessment and evaluation. In mid-2016, a portion of this contract was amended to provide support for implementation of a broader MHSOAC data transparency tool.				
	Deliverable	**Due Date***	**Deliverable Cost**	**Status**
1	Preliminary Statewide FSP Classification System Presentation Based on Focus Groups and/or Interviews	February 27, 2015	$52,650	Completed
2	Report of Proposed Statewide FSP Classification System Based on Stakeholder Input	August 31, 2015	$53,750	Completed
3	Report of Final Statewide FSP Classification System Based on Public Comment	October 30, 2015	$11,225	Completed
4	Report of Online Statewide FSP Classification System Website Version 1.0 Design Specification	February 29, 2016	$56,900	Completed
5	MHSOAC Website Application Configuration Support and Documentation Monthly Progress Reports (10)	From Sept. 30, 2016 to June 30, 2017	$237,663	Completed 8 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, 2017~~ May 31, 2017	$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 5/17/17)

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**	**Completed**
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 5/17/17)

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	Under Review
7	Proposed Statewide Evaluation Plan	June 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 5/17/17)

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 – August 31, 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**~~ **May 30, 2017**	**$75,000**	**Pending**
5	**Policy Brief and Fact Sheet(s)**	~~**April 28, 2017**~~ **August 7, 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 5/17/17)

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 5/17/17)

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**	**Completed**
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 5/17/17)

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 5/17/17)

MHSOAC Evaluation Unit

Mental Health Services Act (MHSA) Performance Monitoring

MHSOAC Staff: Fred Molitor

Active Dates: Ongoing

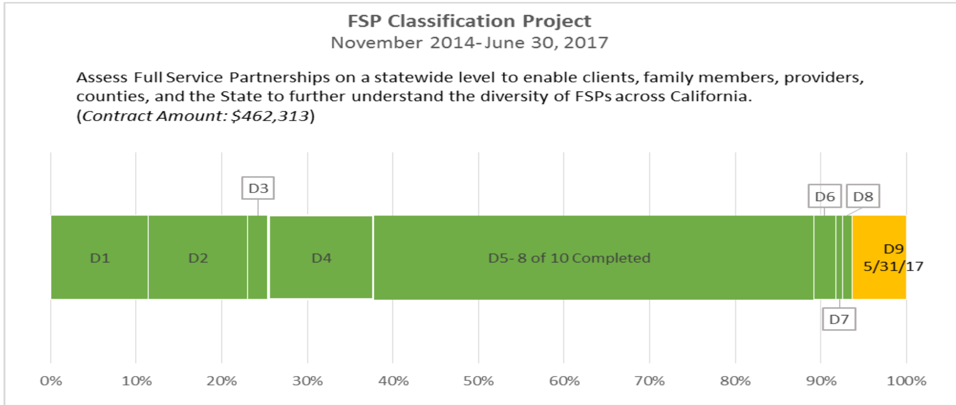
Objectives: Implement a process and system for monitoring and reporting on individual- and system-level data, including the CSI and DCR, to support characterization and assessment of MHSA programs and outcomes.

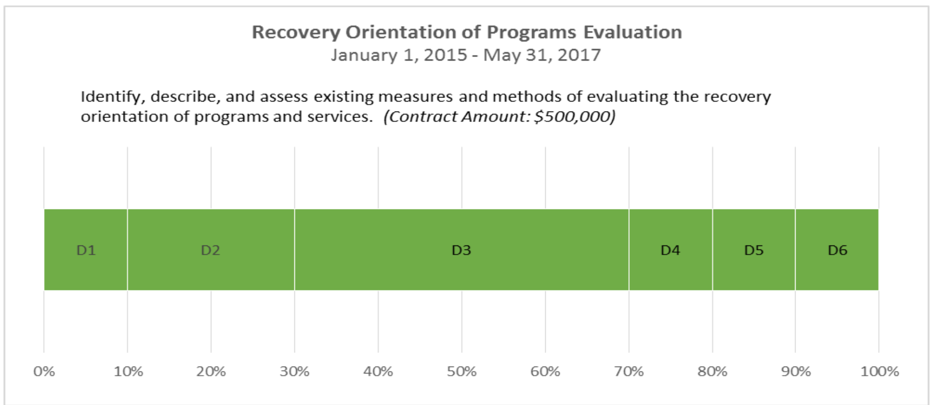
This internal evaluation project is in transition to an external evaluation project.

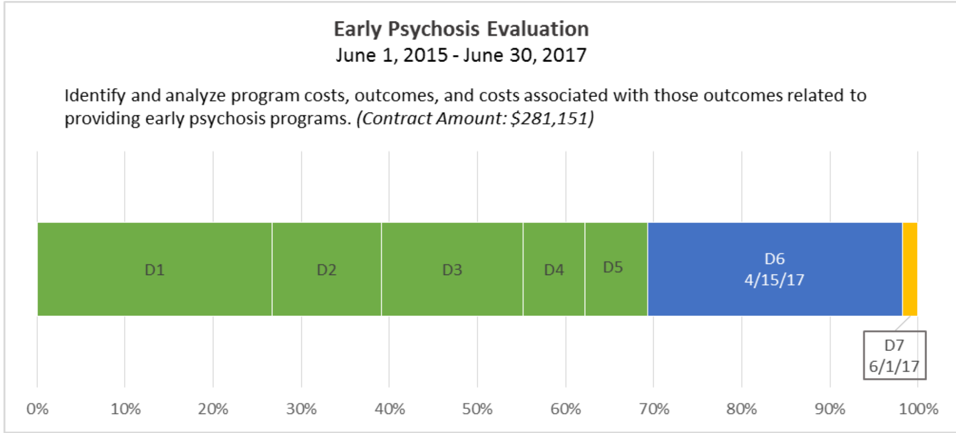
	Work Effort or Product	Due Date	Status
1	**Develop Process For Adding Additional Client, System, And Community-Level Indicators**	**December 31, 2014**	**Completed**
2	**Secure Health Insurance Portability And Accountability Act (HIPAA) Compliance For MHSOAC Staff And Information Systems To Allow Secure 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**

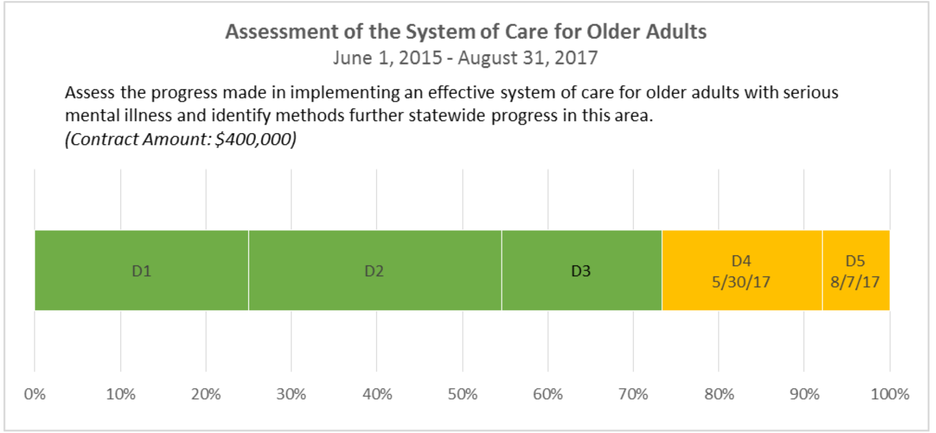
* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

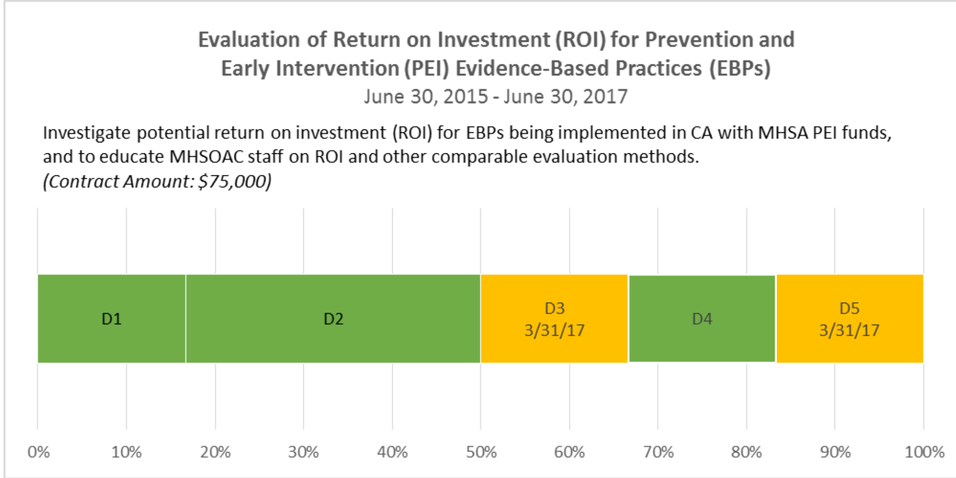
Snapshot of Contract Deliverables

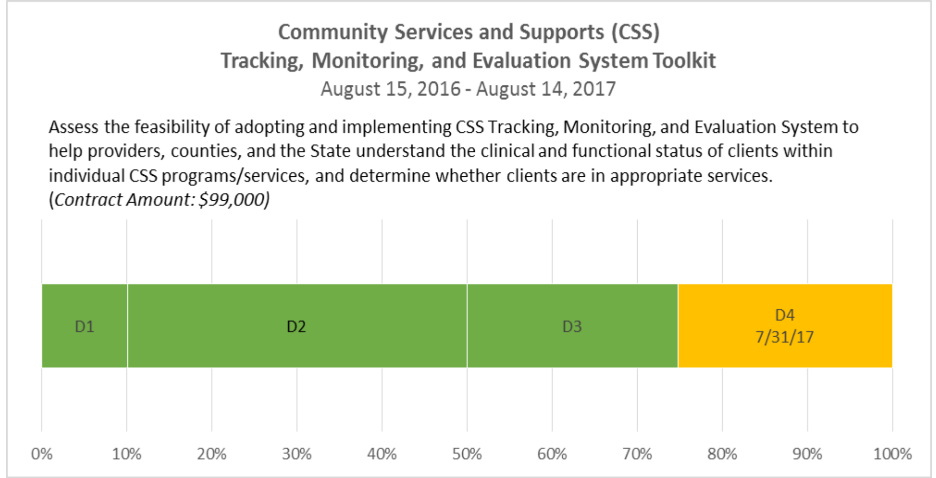












Legend: Deliverable Complete | Deliverable Pending | Deliverable Under Review

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

MHSOAC
Mental Health Services
Oversight & Accountability Commission
1325 J ST STE 1700
SACRAMENTO CA 95814
(916) 445-8696
www.mhsoac.ca.gov

Commission Meeting Schedule 2017

Meeting Date and Location	Group / Topic
Thursday, June 23, 2017 No Meeting	**Commission Meeting** No Meeting
Thursday, July 27, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, August 24, 2017 TBD	**Commission Meeting** Project Meeting
Thursday, September 28, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, October 26, 2017 TBD	**Commission Meeting** Project Meeting
Thursday, November 16, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, December 28, 2017 No Meeting	**Commission Meeting** No Meeting

rev 05/05/2017

Innovation Review Outline

Regulatory Criteria

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

Staff Summary Analysis Includes:

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