WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

May 25, 2017
PowerPoint Presentations and Handouts

Tab 2:	•	**Handout:**	**Revised Financial Report**
	•	**PowerPoint**	**Revised 2017 MHSA Financial Report**
Tab 5:	•	**PowerPoint**	**Amador County MHSA Proposal 1: Circle of Wellness: Mother, Child, and Family**
	•	**PowerPoint**	**Amador County MHSA Innovation Proposal 2: Treatment Group for Teens/TAY with Co-Occurring Mental Health and Substance Use Disorders**
Tab 6:	•	**PowerPoint**	**Ventura County Innovations: Children's Accelerated Access to Treatment and Services (C.A.A.T.S.)**
Tab 7	•	**PowerPoint**	**County of San Diego Behavioral Health Services: MHSA Cycle 4 Innovation Programs**
Tab 8	•	**PowerPoint**	**Request for Funding for Evaluation and Transparency Portal Projects**

Mental Health Services
Oversight & Accountability Commission

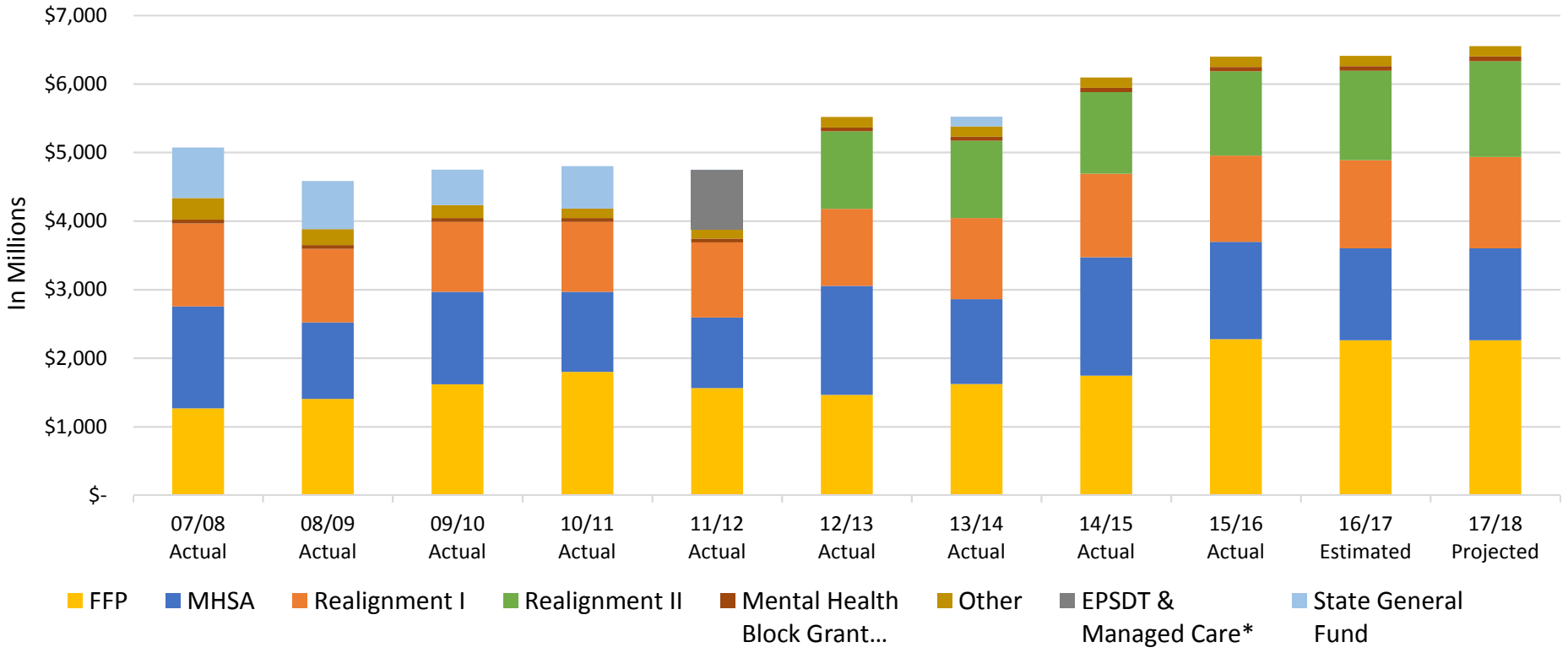
Revised Financial Report

May 25, 2017

Mental Health Funding at the Local Level

FY 07/08 - 17/18

The graph below displays local mental health funding levels from FY 2007/08 to 2017/18 from different funding sources. Projected funding to the counties in FY 2017/18 is 29 percent higher than in FY 2007/08 and 19 percent higher than FY 2012/13.



MHSA funding for counties shown above is from the Governor's proposed budget. Actual amount distributed will be based on actual revenues deposited into the fund less the amount reserved and spent on administration.

Realignment I 1991: Transferred control of several health and mental health programs from the state to the counties, reduced State General Funds to the counties, and provided the counties with "new" tax revenues from increased sales tax and vehicle license fees dedicated to counties for their increased financial obligations for health and mental health programs.

Realignment II 2011: shifts "existing" state revenues from sales tax, vehicle license fee for various programs including EPSDT and mental health managed care. The total funds for the 2011 Realignment includes funds for Substance Use Disorders.

* One time redirected MHSA funding for EPSDT and Mental Health Managed Care. State general funding for mental Health was replaced by Realignment I and Realignment II.

State General Fund for mental health was replaced by Realignment I and Realignment II.

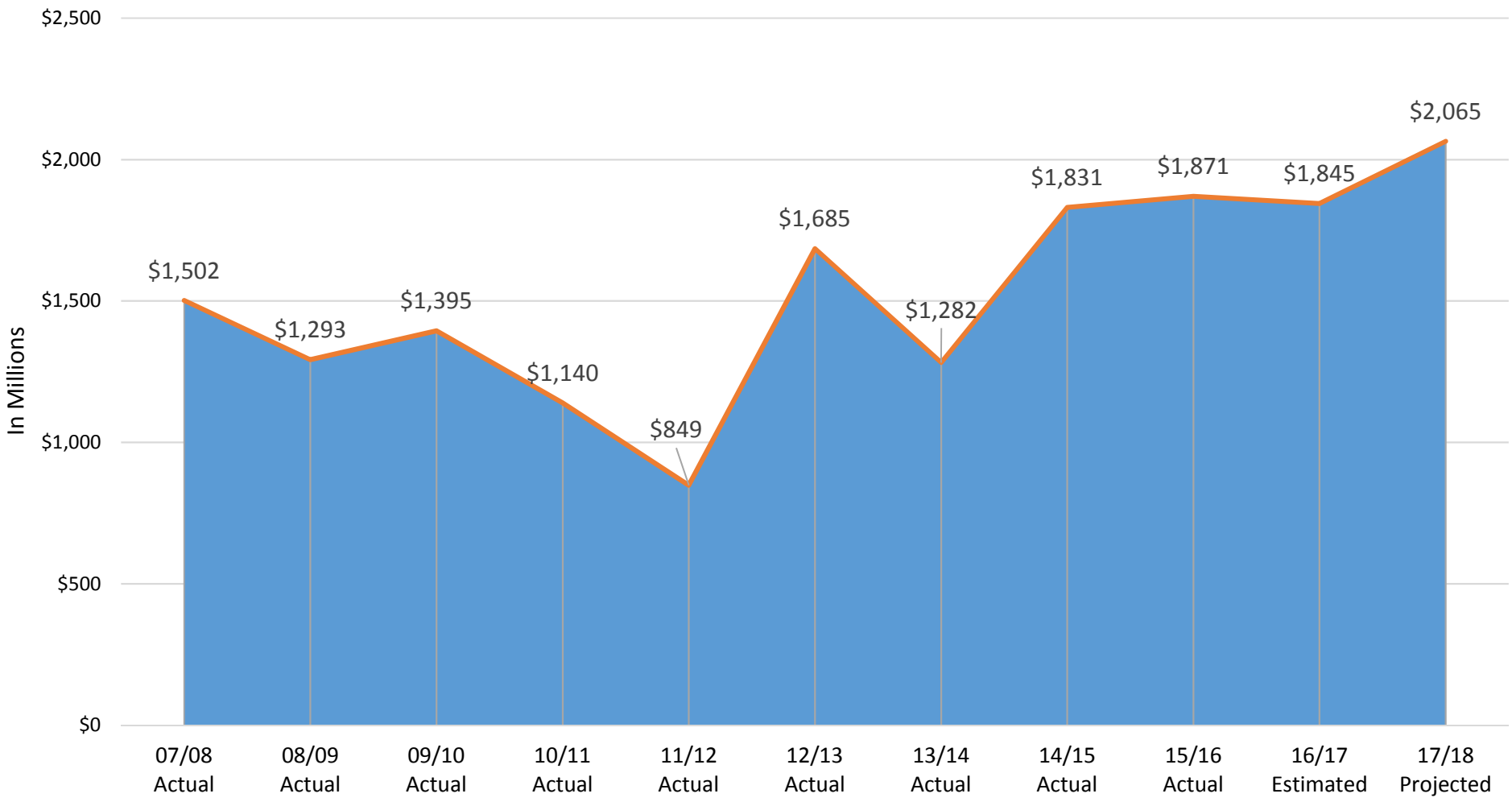
State General Fund in 2013/14 was for the California Health Facilities Financing Authority Senate Bill (SB) 82 Grants.

Source: Sources identified in Appendix 1
May 2017
Updated Semi-Annually

Total MHSA Revenue

FY 07/08 - 17/18

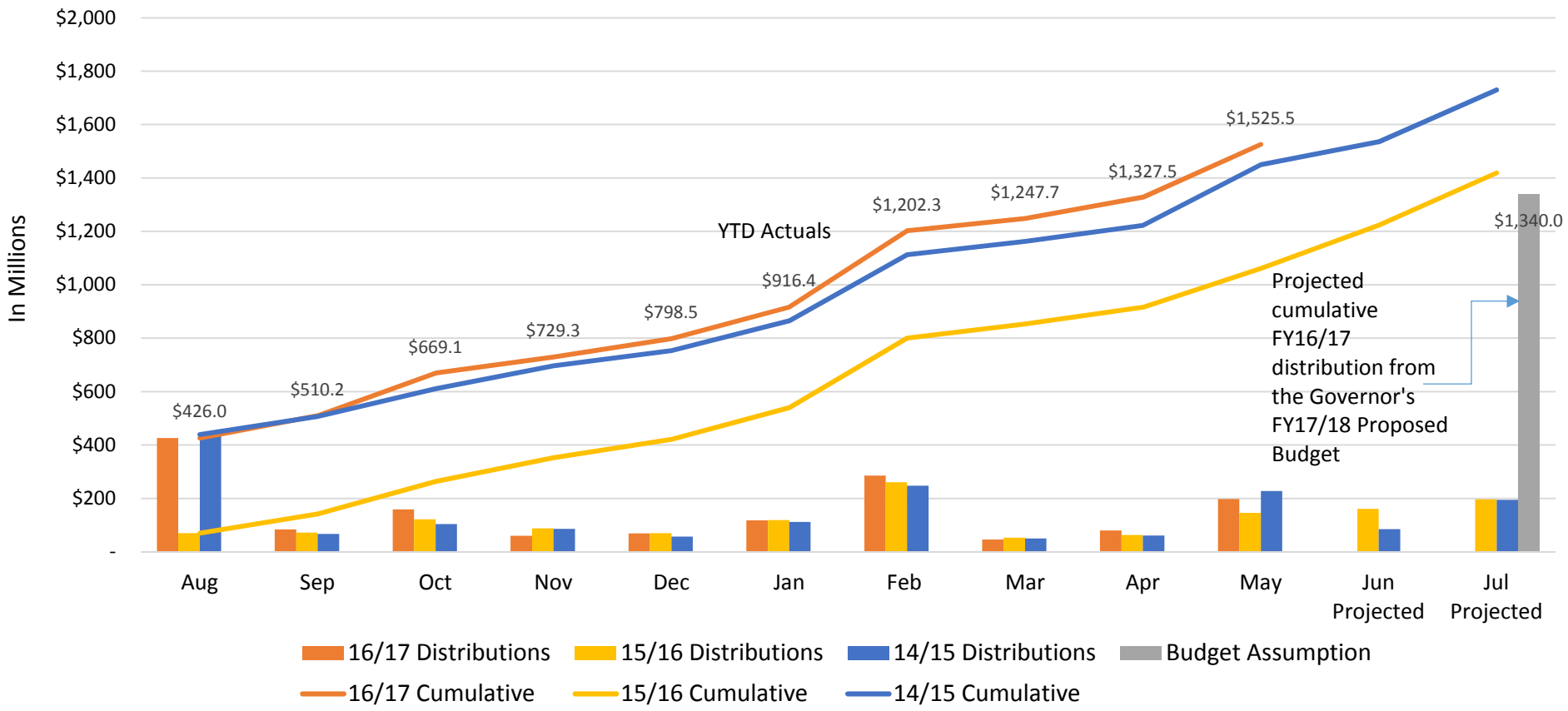
The graph below indicates the actual and estimated total MHSA Revenues deposited to the fund from FY 2007/08 to 2017/18. MHSA funding is susceptible to economic fluctuations as noted in the graph below. Each county is required to maintain a Prudent Reserve that is designed to preserve current levels of services in years with extreme decreases in revenue. Additionally, the State maintains a reserve for economic uncertainties in each special fund. The Governor's FY 2017/18 January Proposed Budget includes a projected reserve in the Mental Health Services Fund for FY 2017/18 of $1,718 million.



Source: Sources identified in Appendix 2
May 2017
Updated Semi-Annually

Mental Health Services Funds Distributed to Counties FY 2016/17

This chart reflects changes to distributions to the counties of MHSA Funds from July 2016 to January 2017. Currently, these funds are no longer distributed by MHSA Component, (Community Services and Supports, Prevention and Early Intervention, Innovation, etc.). The distribution in FY 2016/2017 represents actual Mental Health Services funds distributed for the first 6 months of the fiscal year. Also shown are monthly and cumulative distributions for FY2014/15 and FY2015/16 and the projected cumulative distribution for FY16/17 included in the Governor's Proposed Budget for FY17/18.



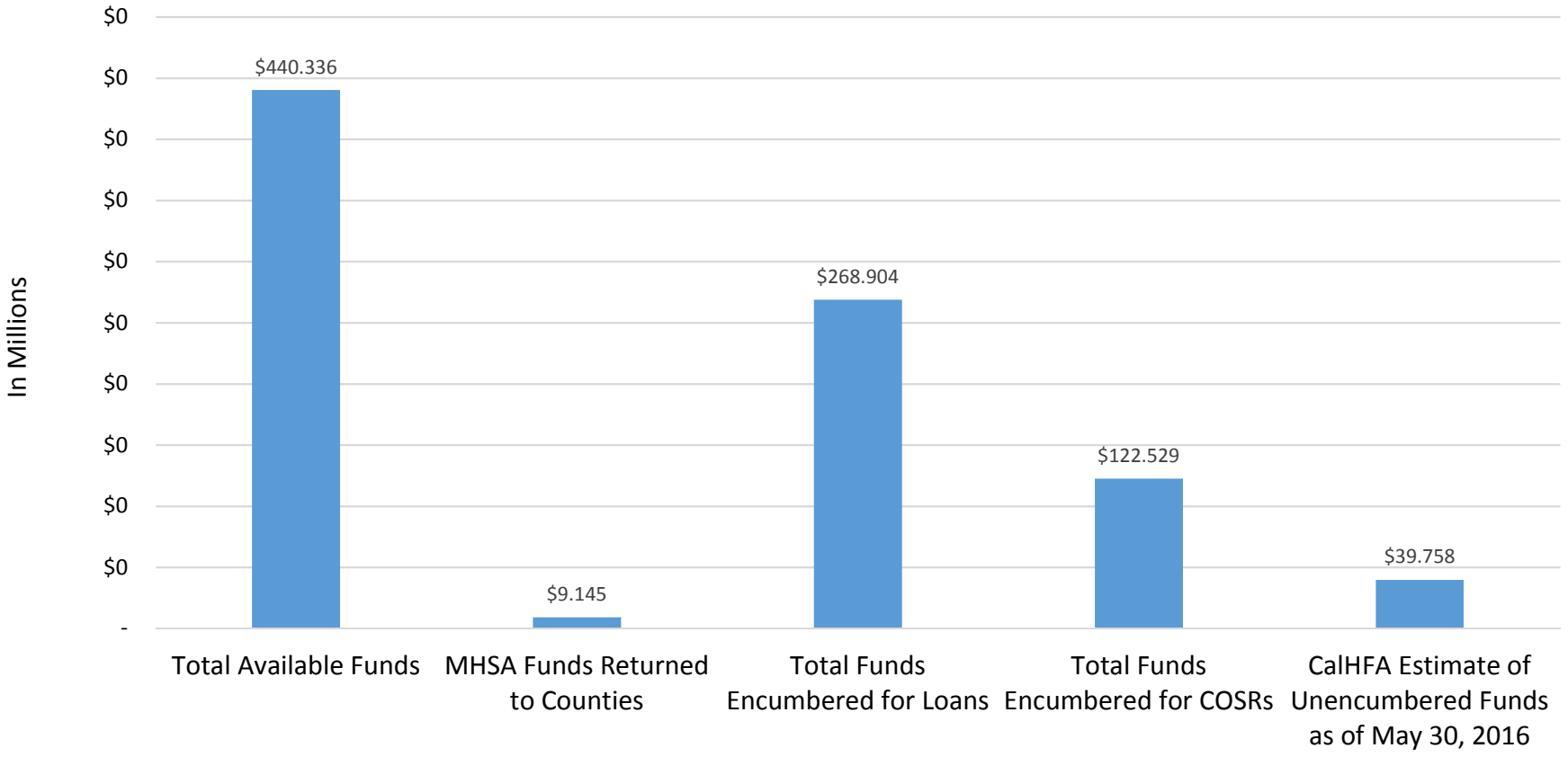
For a year to date, county by county summary of distributions, refer to the following link:
http://www.sco.ca.gov/Files-ARD-Payments/mentalhealthservices_ytd_1617.pdf

Sources: Governor's Proposed Budget, State Controller's Office and MHSOAC Staff Projections
May 2017
Updated Semi-Annually

MHSA Housing Program

FY 15/16

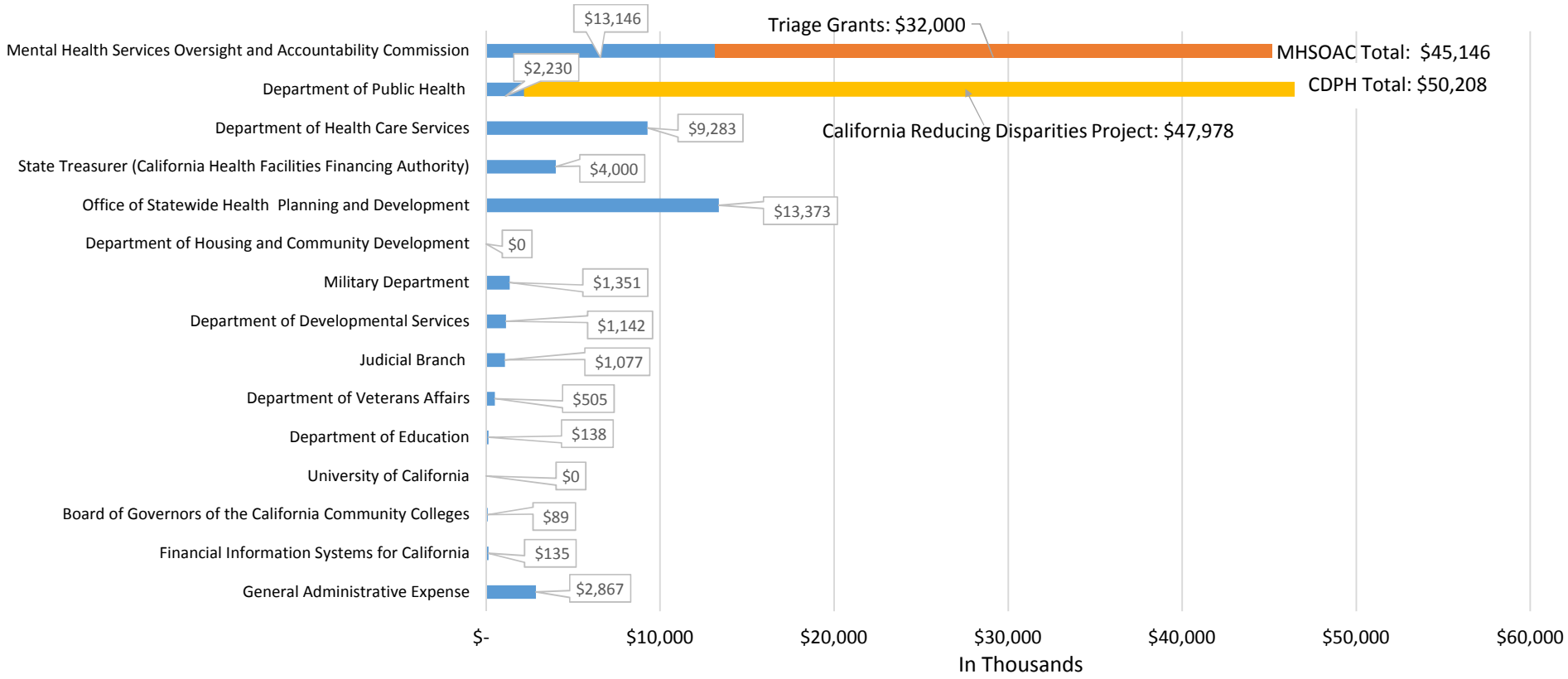
Executive Order S-07-06, signed by Governor Schwarzenegger on May 12, 2006, mandated the establishment of the MHSA Housing Program, with the stated goal of creating 10,000 additional units of permanent supportive housing for persons with serious mental illness who are homeless or at risk of homelessness. In May 2007, $400M of MHSA funds was made available under the MHSA Housing Program. This program makes permanent financing and Capitalized Operating Subsidy Reserves (COSRs) available for the purpose of developing permanent supportive housing, including both rental housing and shared housing, to serve persons with serious mental illness who are homeless or at risk of homelessness. This was a one-time allocation of MHSA funds. The program was closed at the end of Fiscal Year 2015/16, replaced by the Local Government Special Needs Housing Program, administered by the California Housing Finance Agency.



Source: California Housing Financing Agency, http://www.calhfa.ca.gov/multifamily/mhsa/EndOfProgramFundAllocationsByCounty.pdf

MHSA Administration Funds by Department (In Thousands) FY 2017/18

This figure identifies the state entities that receive MHSA Administrative Funds. These funds are utilized for administration, services, research, etc. A portion of these funds were reappropriated from prior year administrative funds and are attributed to the 5% administrative cap for a different fiscal year than which they are expended. Zero amounts are shown for DHCD ($6.2M in 2016/17) and the University of California ($9.8 million in 2016/17). General Administrative Expense is now a general line item in the budget for each fund rather than line items in individual departmental budgets.



Amount Budgeted for Fiscal Year 2017/18 $ 129,314 Projected

Sources: Health and Human Services budget details, FY2017-18 and FY2016-17.

Appendix 1: Mental Health Funding Levels at the Local Level (In Millions) FY 07/08 - 17/18

	07/08 Actual	08/09 Actual	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Actual	15/16 Actual	16/17 Estimated	17/18 Projected
State General Fund	$ 738.5	$ 701.0	$ 518.0	$ 619.4	$ 0.1	$ -	$ 142.5	$ -	$ -	$ -	$ -
Realignment I	$ 1,211.5	$ 1,072.4	$ 1,023.0	$ 1,023.0	$ 1,097.6	$ 1,124.0	$ 1,185.0	$ 1,216.7	$ 1,256.1	$ 1,285.5	$ 1,330.5
Realignment II	$ -	$ -	$ -	$ -	$ -	$ 1,131.0	$ 1,129.0	$ 1,193.0	$ 1,230.3	$ 1,303.4	$ 1,396.6
Mental Health Block Grant (SAMHSA)	$ 55.1	$ 53.7	$ 54.0	$ 53.7	$ 53.1	$ 57.4	$ 57.4	$ 62.2	$ 63.1	$ 69.2	$ 70.2
FFP	$ 1,266.4	$ 1,404.6	$ 1,619.2	$ 1,799.9	$ 1,562.5	$ 1,465.0	$ 1,624.0	$ 1,743.0	$ 2,277.6	$ 2,262.9	$ 2,262.9
MHSA	$ 1,488.2	$ 1,117.0	$ 1,347.0	$ 1,165.1	$ 1,029.9	$ 1,589.0	$ 1,235.0	$ 1,730.1	$ 1,418.8	$ 1,340.0	$ 1,340.0
EPSDT & Managed Care*	$ -	$ -	$ -	$ -	$ 861.2	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ 313.3	$ 233.9	$ 187.6	$ 139.4	$ 139.4	$ 150.0	$ 150.0	$ 150.0	$ 150.0	$ 150.0	$ 150.0
TOTAL	**$ 5,073.0**	**$ 4,582.6**	**$ 4,748.8**	**$ 4,800.5**	**$ 4,743.8**	**$ 5,516.4**	**$ 5,522.9**	**$ 6,094.9**	**$ 6,395.9**	**$ 6,411.0**	**$ 6,550.2**

State General Fund (SGF): Prior to the Governor's FY 2011/12 Budget Proposal, the primary obligations of the SGF provided counties with mental health dollars to fund specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, Early and Periodic Screening Diagnosis Treatment (EPSDT) and Mental Health Services to Special Education Pupils (AB 3632). State General Fund for Mental Health was replaced by Realignment I and Realignment II. State General Fund in 2013/14 was for the California Health Facilities Financing Authority Senate Bill (SB) 82 Grants. These grants subsequently were funded from the MHSF.

Realignment I (1991): In the 1991/92 fiscal year, State-Local Program Realignment restructured the state-county partnership by giving counties increased responsibilities and funding for a number of health, mental health, and social services programs. This realignment provides counties with dedicated tax revenues from the state sales tax and vehicle license fee.

Realignment II (2011): Realignment is the shift of funding and responsibility from the State to the counties to provide mental health services, social services and public health. There are two sources of revenue that fund realignment: 1.0625 cents of State sales taxes and a portion of State vehicle license fees. The primary mental health obligation of realignment is to provide services to individuals who are a danger to self/others or unable to provide for immediate needs. It is also a primary funding source for community-based mental health services, substance abuse services, State hospital services for civil commitments and Institutions for Mental Disease (IMDs) which provide long-term care services. Realignment II is for behavioral health services more broadly. The numbers displayed exclude the fixed set-aside for Women and Children's Residential Treatment.

Mental Health Block Grant (SAMHSA): Mandated by Congress, SAMHSA's block grants are noncompetitive grants that provide funding for substance abuse and mental health services.

Federal Financial Participation (FFP): FFP is the federal reimbursement counties receive for providing specialty mental health treatment to Medi-Cal and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California and which is called the Federal Medical Assistance Percentage (FMAP) and gives counties the funding responsibility for EPSDT and Mental Health Managed Care. California's FMAP for 2017 is 50 percent.

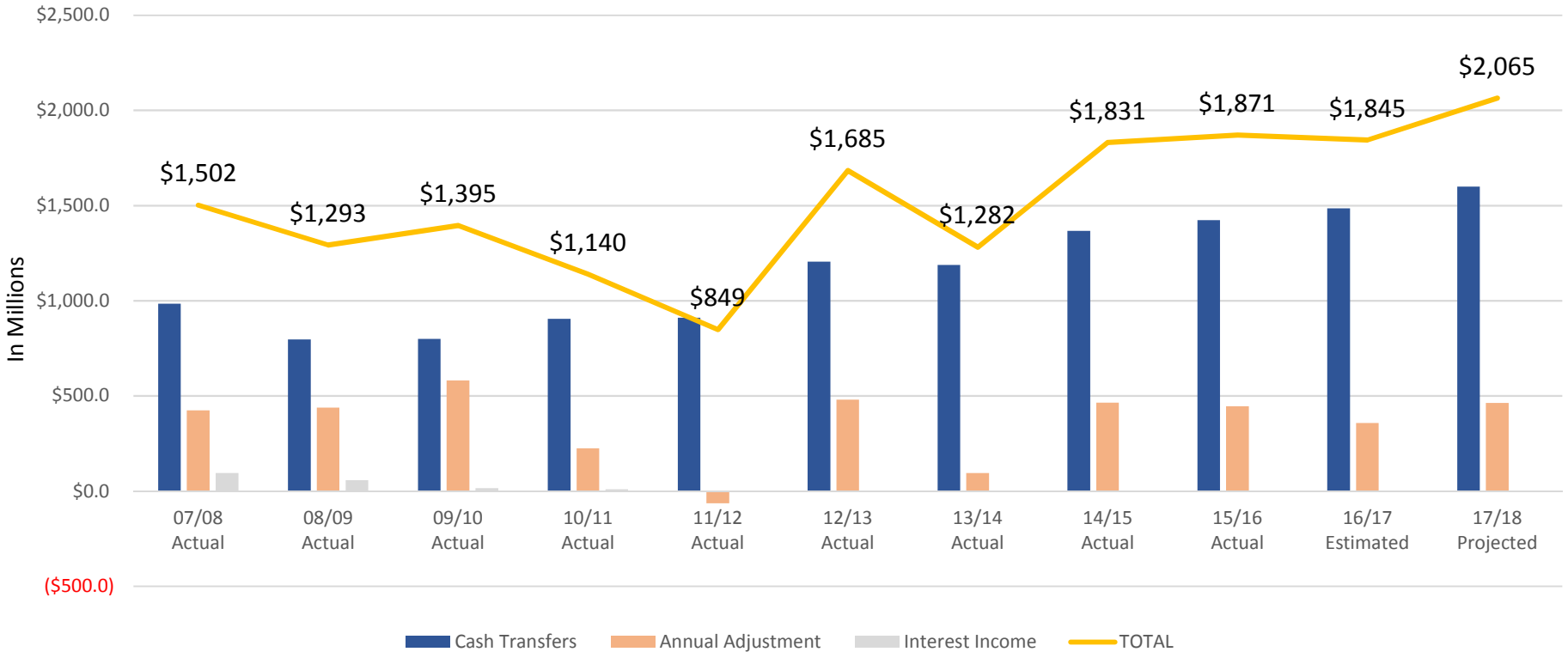
Proposition 63 Funds (MHSA): The MHSA is funded by a 1% tax on personal income in excess of $1 million. The primary obligations of the MHSA is for counties to expand recovery based mental health services, to provide prevention and early intervention services, innovative programs, to educate, train and retain mental health professionals, etc.

Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive Realignment funds). MHSOAC Fiscal Consultant Projections; these have not been updated since 2012/13.

* One time redirected MHSA funding for EPSDT and Mental Health Managed Care.

Appendix 2: Total MHSA Revenue FY 07/08 - 17/18

This graph and chart displays in more detail the information found on the graph on page two, Total MHSA Revenue . The dollars identified below tie to Fund Condition Statement figures published by DOF.



	07/08 Actual	08/09 Actual	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Actual	15/16 Actual	16/17 Estimated	17/18 Projected
Cash Transfers	$983.9	$797.0	$799.0	$905.0	$910.0	$1,204.4	$1,187.4	$1,366.5	$1,423.5	$1,485.4	$1,599.5
Annual Adjustment	$423.7	$438.0	$581.0	$225.0	($64.0)	$479.8	$94.3	$464.1	$446.0	$357.5	$463.4
Interest Income	$94.4	$57.6	$14.9	$9.7	$2.7	$0.7	$0.5	$0.8	$1.2	$1.9	$1.9
TOTAL	$1,502.0	$1,292.6	$1,394.9	$1,139.7	$848.7	$1,684.9	$1,282.2	$1,831.5	$1,870.8	$1,844.8	$2,064.8

Mental Health Services
Oversight & Accountability Commission

Revised 2017 MHSA Financial Report

May 25, 2017

WELLNESS • RECOVERY • RESILIENCE

Revisions from the January Report

- The May 2017 Financial Report contains minor changes to projected MHSA revenues for FY 2016-17 and FY 2017-18.
- Projected MHSA revenue is down one percent for FY 2016-17 but up 9 percent for FY 2017-18 from the January budget.
- Projected distributions to the Counties from MHSF for FY 2016-17 are up 4.1 percent from January.* Year over year, monthly distributions were sharply higher this year over last year in February and May, corresponding to quarterly PIT payments.
- Through May, distributions to Counties are up 44 percent from this point last year, but up only 5 percent from this point in 2014-15

Amador County

Behavioral Health Services

MHSA Innovation Proposal 1

Circle of Wellness: Mother, Child, and Family

Amador County

Behavioral Health Services

County Profile

- Approximately 283 births annually
- Home to three federally-recognized tribes
- MACT Health Board provides services to Native American and Non-native residents

Amador County
Behavioral Health Services

Primary Problem

- Compared to California (8.2 per 1000) the rate of substantiated allegations of child maltreatment is 18.3 per 1000
- Behavioral health and obstetric care are not integrated
- Native American women and women without a medical home are un- or under served
- Absence of early identification allows perinatal mental health problems to escalate to the point of crisis

Amador County
Behavioral Health Services

Proposed Project/ Response

- Establishes a collaborative to identify and address the medical, emotional and concrete needs of un- or underserved pregnant women
- Serves 25-30 pregnant women and their children using a two-path response system
- Provides case management to stabilize families
- Builds the capacity of community providers to address perinatal mood and anxiety disorders
- Supports optimal attachment and child development

Amador County
Behavioral Health Services

Learning Objectives

- Does the proposed project decrease or eliminate the use of hospital emergency rooms for mental health care?
- Does integrating mental health care as a component of routine OB care reduce stigma?
- Does the collaborative approach meet the needs of un- and underserved women in the perinatal period?

Amador County
Behavioral Health Services

Project Evaluation

- Women receiving perinatal care at a medical clinic in a nearby county will serve as a comparison condition
- Quasi-experimental evaluation design
- Measure collaboration function and quality
- Measure maternal mental health, child health and development and family outcomes

Amador County

Behavioral Health Services

Stakeholder Engagement

- Project idea emerged from the Amador/ Calaveras Perinatal Wellness Coalition; a diverse and multi-sector group
- Input provided by community feedback group of the MHSA Cultural Competency Committee
- Project idea endorsed by the Amador County Behavioral Health Advisory Board with public input

Amador County

Behavioral Health Services

Q & A

Amador County
Behavioral Health Services

MHSA Innovation Proposal 2

- Treatment Group for Teens/TAY with Co-Occurring Mental Health and Substance Use Disorders

Amador County

Behavioral Health Services

County Profile

- 595 square miles, western Sierra Nevada foothills, rural in character, southeast of Sacramento
- 13% of adults and 23% of children live in poverty
- Attainment of post secondary degrees is significantly lower than in the state and U.S.

Amador County

Behavioral Health Services

Primary Problem

- Current treatment model has not effectively served teens/TAY with co-occurring disorders
- Compared to California (8.2 per 1000) the rate of substantiated allegations of child maltreatment is 18.3 per 1000.
- Among the population 12-17, it is estimated that 8.6% need mental health services
- Remote areas face transportation challenges

Amador County
Behavioral Health Services

Proposed Project/ Response

- Enhances and expands identification and referral of teens/ TAY who may be suffering from COD
- Serves a standing group of 15; up to 30 youth per year
- Codifies culturally relevant and effective interventions for target population
- Backs up anecdotal success with measurement and evaluation
- Relapse prevention and recovery community

Amador County
Behavioral Health Services

Learning Objectives

- Determine whether a curriculum designed to support local TAY increases program graduation and promotes recovery at a rate exceeding “business as usual.”
- Does understanding the neurological basis of their diagnoses promote recovery among traumatized youth with COD?
- Through customized intervention, can initially asocial youth with COD assume leadership roles?

Amador County

Behavioral Health Services

Project Evaluation

- Youth on a waiting list will form a comparison condition.
- Multiple baseline evaluation design
- Individual, relational, family and system outcomes are measured.

Amador County
Behavioral Health Services

Stakeholder Engagement

- Diverse stakeholder representation (including TAY and youth-serving organizations).
- Multiple methods employed to solicit input
- Well-balanced response to community survey.
- Just 13% of survey respondents were not ready to support this project.

Amador County

Behavioral Health Services

Q & A

Proposed Motion

- **Proposed Motion:** The MHSOAC approves Amador's Innovation Projects, as follows:

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

- **Name:** Co-Occurring Group for Teens
- **Amount:** $787,686
- **Project Length:** Five (5)

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Healthcare Agency

May 25th, 2017

VENTURA COUNTY INNOVATIONS:

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

Kiran Sahota, MHSA Manager, Dina Oilvas, Behavioral Health Manager, Hilary Carson INN Administrator

Children's Accelerated Access to Treatment and Services

Program Goal: To improve access and quality of mental health services through a comprehensive intake process that includes mental health assessments, coordinated interagency services linkages, medication support, and clinical intervention for all youth entering the child welfare system.

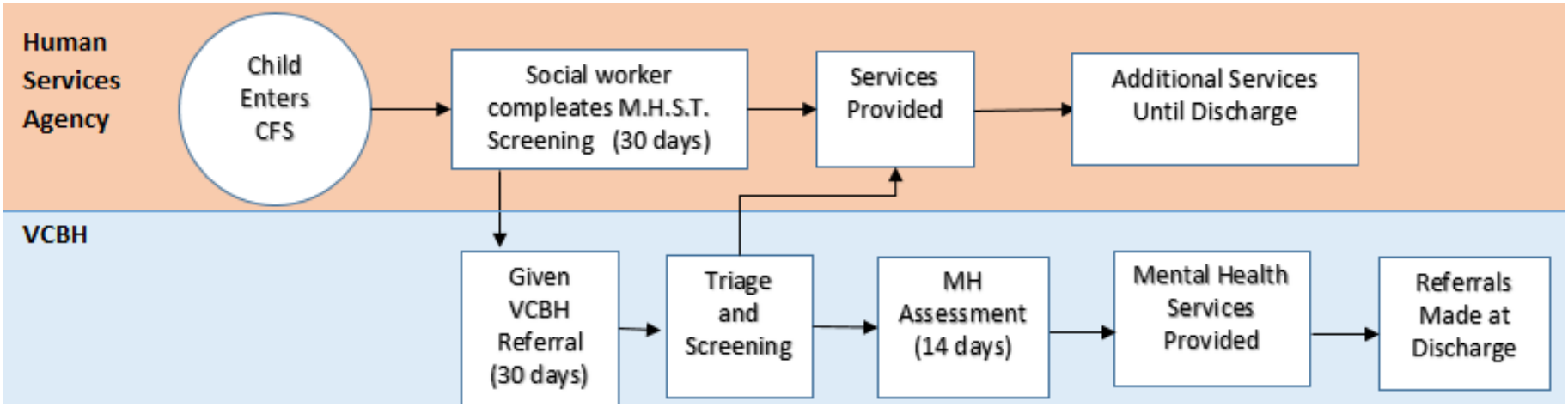
Primary Purpose: To improve quality of services for foster youth

Perceived Positive Individual Outcomes
• **Reduction in symptoms of traumatic stress**
• **Improvement of youth's resilience**
• **Lower levels of risk taking behaviors**
• **Improvement in foster youth's overall functioning**
• **Improved access to and compliance with psychotropic medication**

VENTURA COUNTY BEHAVIORAL HEALTH

Foster Youth and Mental Health: Current Issues

- Higher rates of emotional and behavioral disorders
- Removal from the home is a traumatic experience
- Mental Health system design excludes at-risk youth.
- Delays in accessing mental health services: prolonged assessment process, waiting lists, treatment need determined by caregivers post-entry.
- Difficulty in oversight for youth on psychotropic medications

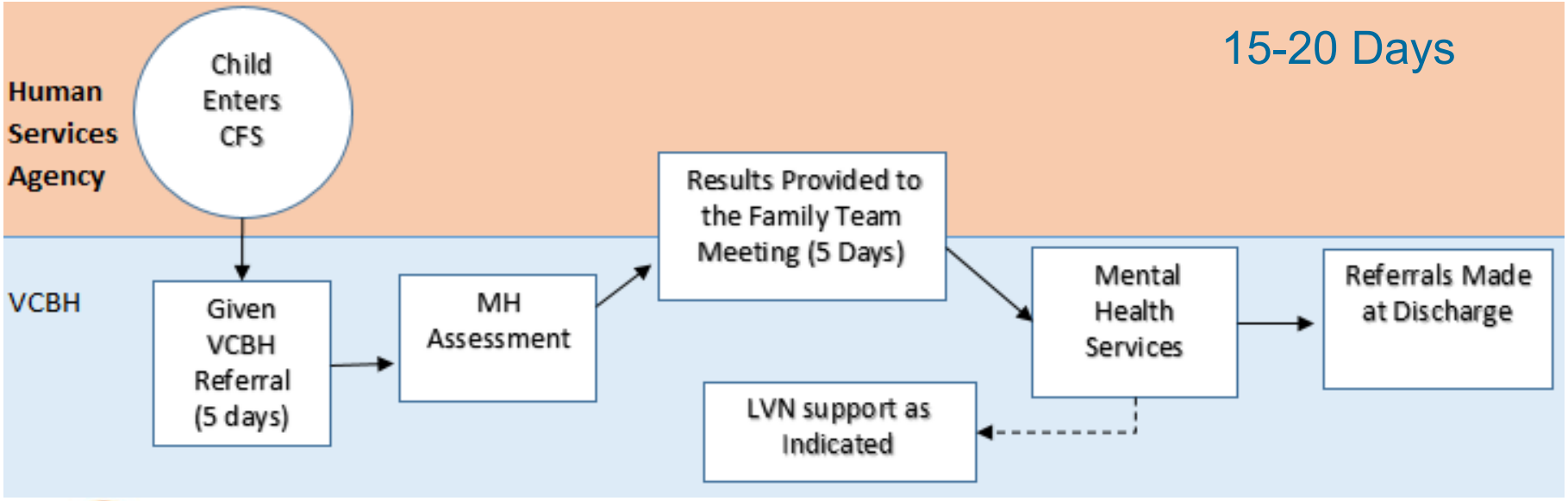


45-60 Days

VENTURA COUNTY BEHAVIORAL HEALTH

Foster Youth and Mental Health: Proposed Changes: C.A.A.T.S

- Youth entering the system receive an expedited (15 day) trauma informed mental health assessment that includes the CANS-Trauma Comprehensive.
- Clinicians that are specially trained to speak to all county based services.
- Mental health services provided for all foster youth.
- Additional monitoring and support for youth prescribed psychotropic medication.



VENTURA COUNTY BEHAVIORAL HEALTH

Evaluation: Questions and Measurable Outcomes

Research Question	Indicator	Measures being considered
1. What are the levels of traumatic stress in foster youth?	Clinical Profile	CANS –Trauma and MHSA demographics form
2. Does an expedited process improve outcomes for foster youth and caregiver(s)?	Timely Access	Tracking of service delivery and key events through Avatar
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?	Mental Health Status and subsection focus for mild to moderate youth	CANS –Trauma and psychosocial assessment. Focus groups with mental health providers and with parents/caregivers.
4. Does providing a comprehensive intake assessment and services lead to lower rates of reentry?	Reentry rates within 12 months of reunification	Child Welfare Indicators Project
5. Does providing support, education, and oversight from an LVN lead to better access to and compliance with psychotropic medication?	Psychiatry attendance rates and reported adherence	Surveys given to caregivers and youth. Tracking of psychiatry appointment attendance in Avatar

Budget

BUDGET TOTALS	FY 17-18	FY 18-19	FY 19-20	Totals
Personnel	587,229	616,591	647,420	1,851,240
Direct Costs	75,421	79,192	83,152	237,765
Indirect Costs				
Non-recurring costs	180,622	25,750	27,038	233,410
Other Expenditures	126,491	108,230	113,641	348,362
TOTAL INNOVATION BUDGET	969,763	829,763	871,251	2,670,777

Additional expenditures for this INN Project & funding sources:		FY 17-18	FY 18-19	FY 19-20	Totals
1.	Innovative MHSA Funds	534,365	457,221	480,082	1,471,668
2.	Federal Financial Participation	435,398	372,542	391,169	1,199,109
3.	Total Proposed Expenditures	969,763	829,763	871,251	2,670,777

Evaluation	$41,450	$41,450	$41,450	$124,350

VENTURA COUNTY BEHAVIORAL HEALTH

Questions?

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kiran.sahota@ventura.org

Hilary Carson
805-981-8496
hilary.carson@ventura.org

VENTURA COUNTY
BEHAVIORAL HEALTH

Proposed Motion

- **Proposed Motion:** The MHSOAC approves Ventura County's Innovation Project, as follows:
- **Name:** Children's Accelerated Access to Treatment and Services (CAATS)
- **Amount:** $2,670,777
- **Project Length:** Three (3) Years

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

MHSA CYCLE 4 INNOVATION PROGRAMS

Alfredo Aguirre, LCSW, Director
Piedad Garcia, EdD, LCSW, Deputy Director
Yael Koenig, LCSW, Deputy Director
Jeffrey Rowe, MD, Supervising Psychiatrist

LIVE WELL SAN DIEGO

Presentation Outline

1. *Live Well San Diego*

2. San Diego Demographics & Population Characteristics

3. San Diego Community Planning Process

4. Cycle 4 Requests

    a) Roaming Outpatient Access Mobile (ROAM) Services
    b) Recuperative Services Treatment (ReST) Housing
    c) Medication Clinic

COUNTY OF SAN DIEGO VISION

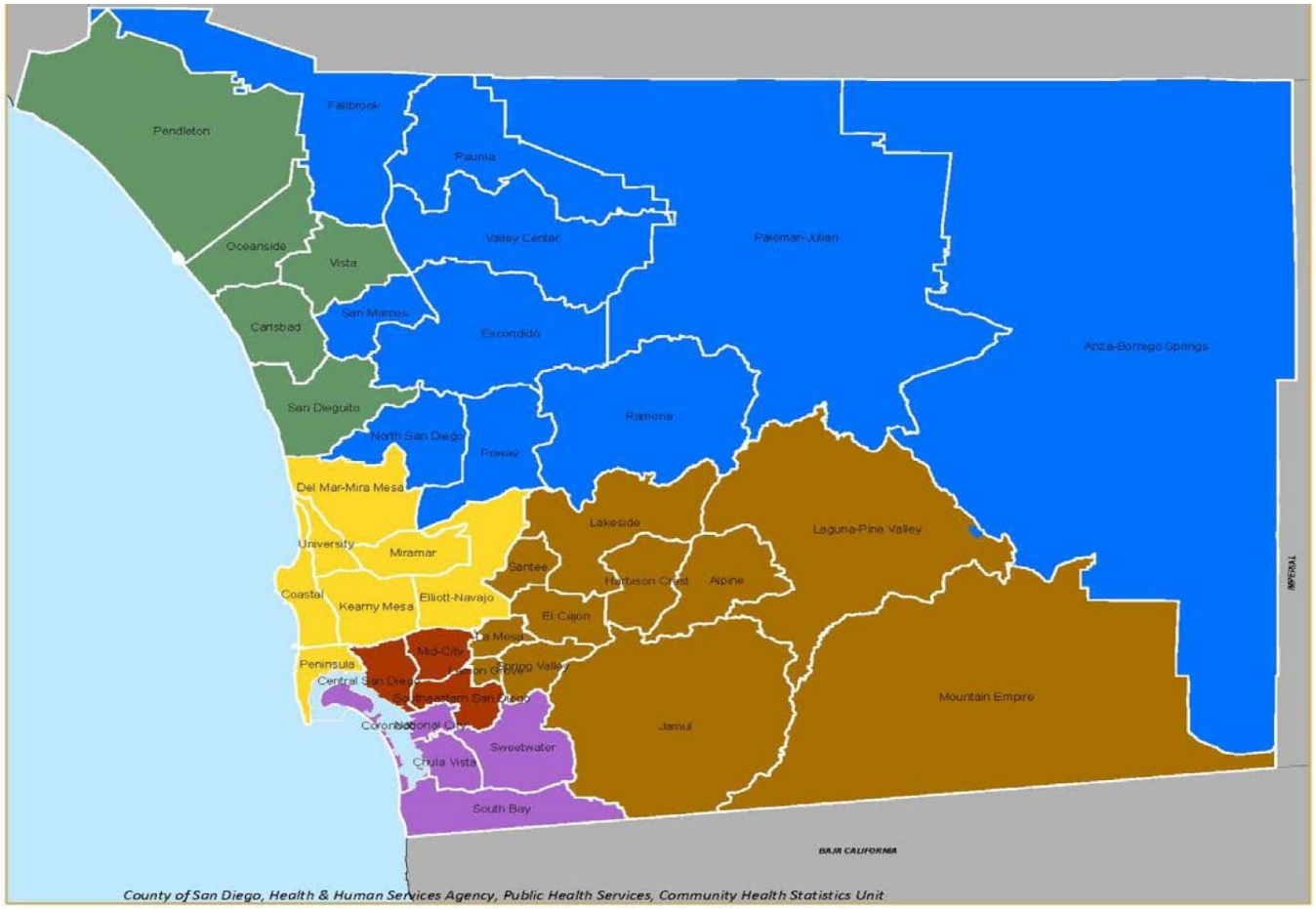
LIVE WELL SAN DIEGO

Building Better Health

Living Safely

Thriving

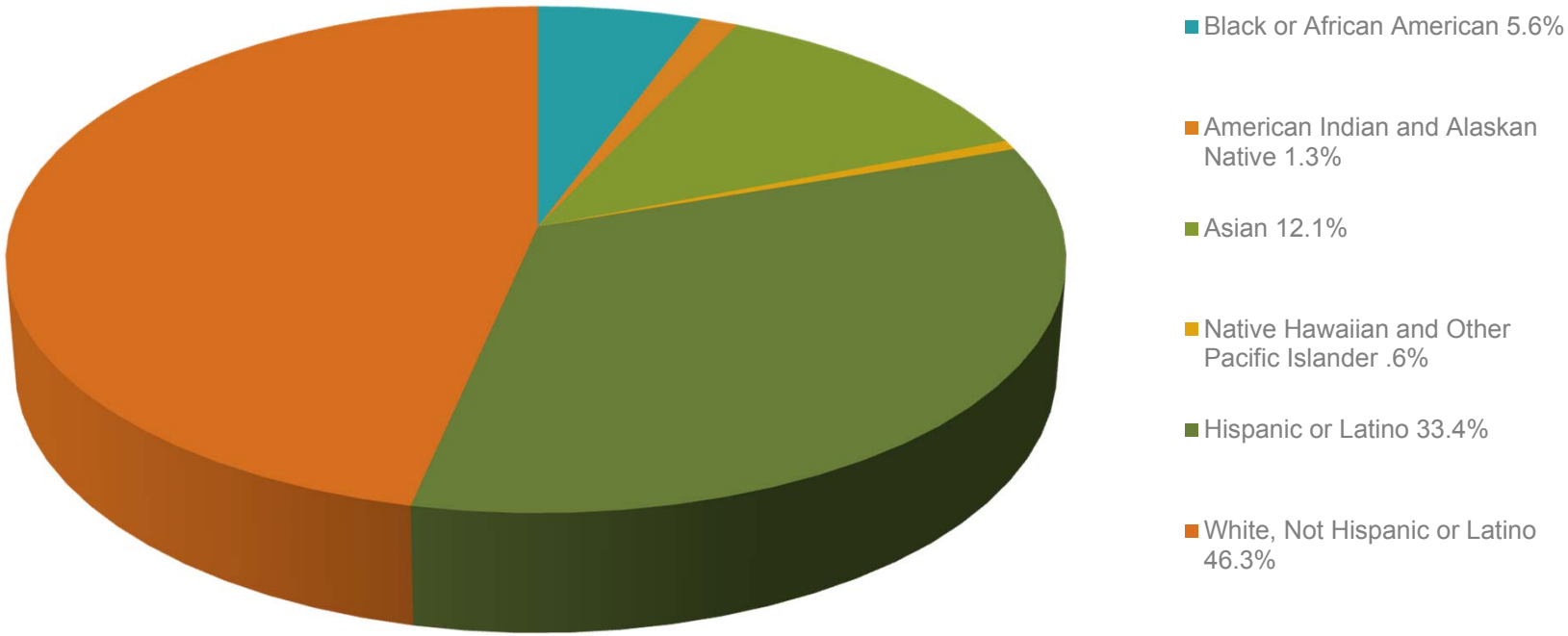
COUNTY OF SAN DIEGO DEMOGRAPHICS



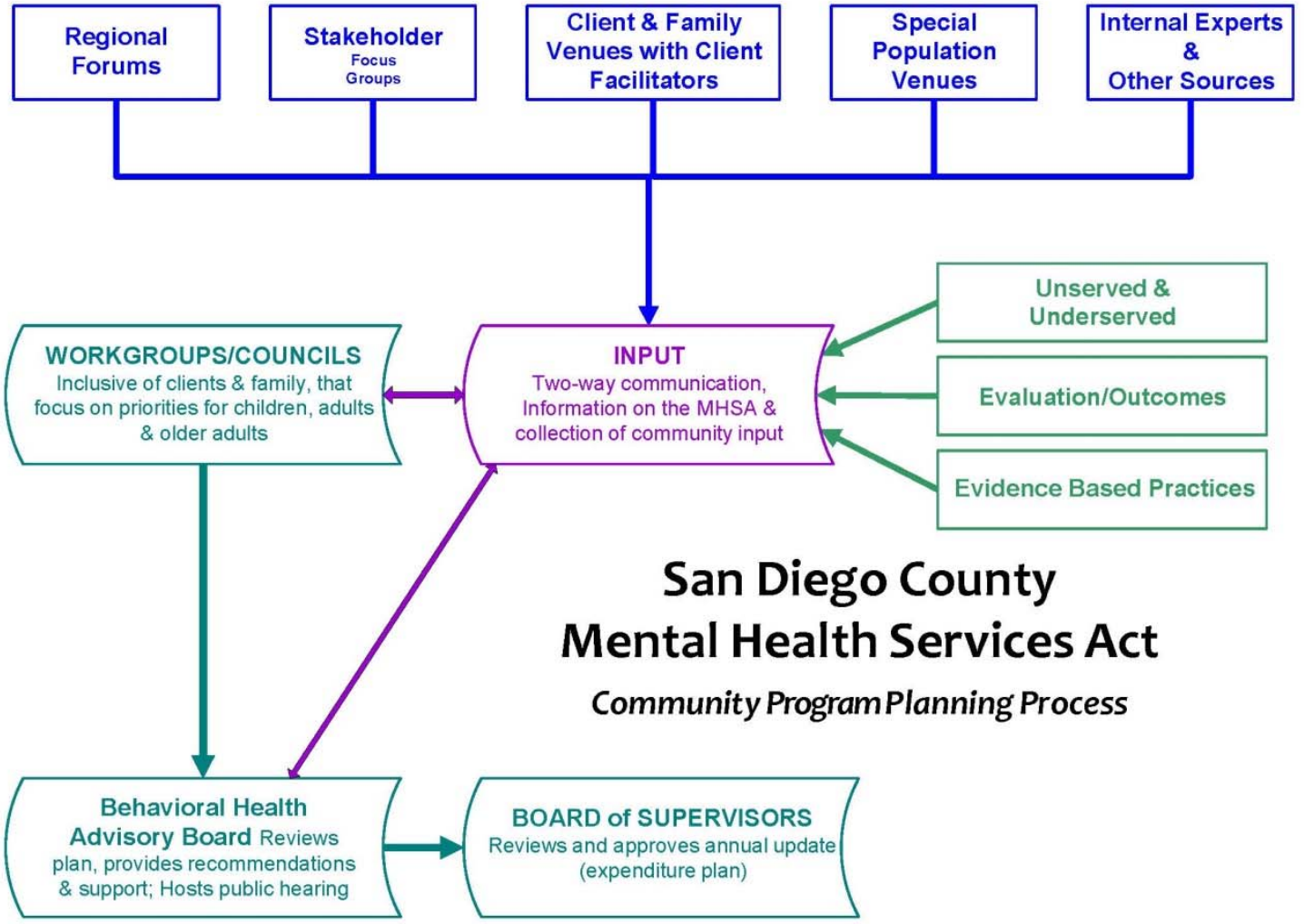
- Total SD County Population: Over 3 Million
- Total Medi-Cal Population: over 820,000
- SD County Land Area: 4,206.63 Square Miles
  (80 miles x 50 miles approx.)

DEMOGRAPHICS CONTINUED

Population Characteristics



COMMUNITY PROGRAM PLANNING PROCESS



MHSA INNOVATION PROPOSAL

LIVE WELL SAN DIEGO

Roaming Outpatient Access Mobile (ROAM) Services

Piedad Garcia, EdD, LCSW
Deputy Director

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES

LIVE WELL SAN DIEGO

Identified Problems

- There are more Native American Reservations in San Diego County than any other county in the United States.
- Over 21,000 Native American residents live in San Diego County.
- Native Americans have the same behavioral health needs as other communities. Factors such as culture, history and geography serve as unique factors to consider in the provision of treatment.
- Geographical isolation (many communities live in remote regions) makes it difficult to access services; many members land some tribes are located many miles away from any services.

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES

Program Description

- Two fully mobile clinics, each assigned to a region (North Inland or East County).
- Each mobile clinic will be based and deployed to locations within their assigned region.
- The team consists of clinical staff, peer and family specialists, and cultural brokers.
- The target population are children, youth, families, adults and older adults.
- Annual unique clients: **120-140** (total for both teams)

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES

LIVE WELL SAN DIEGO

Innovation Components

- Including cultural brokers as staff and incorporation of culturally relevant traditional Native American healing practices in interventions and treatment plan.
- Providing behavioral health services on mobile clinics.
- Utilizing Medication Assisted Services (MAT) for individuals with co-occurring disorders.
- Augmenting service delivery through usage of tele-mental health.

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES

LIVE WELL SAN DIEGO

Learning / Study Questions

- Will the use of a focused, dedicated culturally competent mental health mobile clinic improve access to and utilization of 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 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?

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES

LIVE WELL SAN DIEGO

Program Outcome Objectives

- Improved access to and utilization of culturally competent mental health treatment and services to the Native American community.
- Decrease the effects of untreated mental health illness among Native American individuals.
- Decrease behavioral health symptoms and improve level of functioning of clients.

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) SERVICES

ROAM PROJECTED COST – BOTH CLINICS

Annual Budget:	**$ 1,846,408**		**Total Project Cost:**	**$ 8,788, 837**		
Project Duration:	4.5 Years					
Budget	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23 (Half year only)	Total
Salaries & Benefits	$ 1,331,200	$ 1,331,200	$ 1,331,200	$ 1,331,200	$ 665,600	$ 5,990,400
Operating Cost	$ 258,960	$ 258,960	$ 258,960	$ 258,960	$ 129,480	$ 1,165,320
Indirect Cost	$ 168,324	$ 168,324	$ 168,324	$ 168,324	$ 84,162	$ 757,458
Non Recurring Cost	$ 480,000					$ 480,000
Evaluation*	$ 87,924	$ 87,924	$ 87,924	$ 87,924	$ 87,924	
Projected Annual Budget	**$ 2,326,408**	**$ 1,846,408**	**$ 1,846,408**	**$ 1,846,408**	**$ 923,204**	**$ 8,788, 837**

* Evaluation is 5% of Salaries & Benefits + Direct Costs + Indirect Costs

MHSA INNOVATION PROPOSAL

LIVE WELL SAN DIEGO

Recuperative Services Treatment (ReST) Housing

Piedad Garcia, EdD, LCSW

Deputy Director

RECUPERATIVE SERVICES TREATMENT

Identified Problems

- There are Transitional Aged Youth (TAY) with Severe Mental Illness (SMI), who are homeless, and utilize acute/emergency mental health services, but are otherwise “unconnected” to services.
- In FY 15/16, there were 196 unconnected, homeless TAY who accessed acute/emergency mental health services.
- Among the 196, there were repeated inappropriate utilization of acute services.
- In 2017, San Diego’s Point In Time Count showed 1082 TAY who identified as homeless.

RECUPERATIVE SERVICES TREATMENT

Program Description

- Provide recuperative and habilitative mental health care services.
- Services are up to 90 days with focus on providing clients with a different experience of mental health system and engagement and linkage to ongoing treatment.
- Option of “mentorship” for 30-60 days post completion of ReST.

RECUPERATIVE SERVICES TREATMENT

Program Description

- Target population: Transitional Aged Youth (TAY) with severe mental illness (SMI) who:
  - Require habilitative services post discharge from acute care settings,
  - Are homeless or at-risk of homelessness,
  - Are unconnected to mental health treatment, and
  - Have repeated utilization of inappropriate levels of care

- Annual unique clients: **48-60**

RECUPERATIVE SERVICES TREATMENT

Innovation components

- Providing habilitative mental health services – adapted from medical field's recuperative services.
- Co-location of housing and mental health services post-psychiatric hospitalization and incarceration.
- Usage of Medication Assisted Treatment (MAT) in conjunction with psychotropic medications.
- Connect TAY with Peer Support Specialist mentors for up to 30-60 days post-completion of ReST, if additional support is needed.

RECUPERATIVE SERVICES TREATMENT

Learning / Study Questions

- Does the respite care and habilitation model demonstrate success in penetration and retention of TAY who are unconnected to treatment and repeatedly utilized 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?

RECUPERATIVE SERVICES TREATMENT

Learning / Study Questions

- 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?

RECUPERATIVE SERVICES TREATMENT

Program Outcome Objectives
➢ Decrease unconnected TAY's inappropriate utilization of acute care services and/or returning to jail.
➢ Increase TAY's ability to manage their symptoms and improve their level of functioning and ability to live independently.
➢ Increase connection with an ongoing outpatient mental health program.

RECUPERATIVE SERVICES TREATMENT

ReST PROJECTED COST

Annual Budget: $ 1,362,141 | **Total Project Cost: $ 6,155, 625**

Project Duration: 4.5 Years

Budget	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23 (Half year only)	Total
Salaries & Benefits	$ 642,200	$ 642,200	$ 642,200	$ 642,200	$ 321,100	$ 2,889,900
Operating Cost	$ 615,180	$ 615,180	$ 615,180	$ 615,180	$ 307,590	$ 2,768,310
Indirect Cost	$ 39,897	$ 39,897	$ 39,897	$ 39,897	$ 19,948	$ 179,537
Non Recurring Cost	$ 26,000					$ 26,000
Evaluation*	$ 64,864	$ 64,864	$ 64,864	$ 64,864	$ 32,431	$ 291,877
Projected Annual Budget	**$ 1,388,141**	**$ 1,362,141**	**$ 1,362,141**	**$ 1,362,141**	**$ 681,070**	**$ 6,155, 624**

* Evaluation is 5% of Salaries & Benefits + Direct Costs + Indirect Costs

MHSA INNOVATION PROPOSAL

LIVE WELL SAN DIEGO

Medication Clinic

Yael Koenig, LCSW,

Deputy Director

Jeffrey Rowe, MD

Supervising Psychiatrist

The Identified Problems

1. Populations with Difficulty Accessing Care

- Children and youth with severe, persistent medical problems and complex behavioral health problems
- Children and youth who have completed the psychotherapy part of treatment, but could benefit from continued treatment with psychotropic medication
  - (including long-acting injectable antipsychotic medication treatment)
  - (serious conditions / complex medication regiments)
- Children and youth new to the area who received care in their previous community

The Identified Problems

2. Lack of a Center of Excellence of Child and Adolescent Psychiatry for Families

- Resource center for families (videos, materials, literature)
- Monthly educational presentations for families (conditions, treatments)

MEDICATION CLINIC

Innovation Components

1. Access to Care

- Place a psychiatrist in a “Pediatric Special-Needs Clinic”
- Provide Tele-psychiatry medication support services to 2 locations in each region of the County (total of 12 sights)
- Central office for medication support with services available up to age 21, if needed
- Injectable medication clinic
- Consultation to schools, primary care groups, Child Welfare Services, Probation Department, Regional Center
- Care coordination of services, interaction with consultees, referral to “full service clinic” if child/youth require individual and/or family psychotherapy

Innovation Components

2. Center of Excellence for Families

- Monthly presentations of psychiatric topics on conditions, treatments, new trends, new understandings about children, youth, and family function
- Monthly Resource Fairs for youth and families to view and obtain videos, pamphlets, books, and other tools
- Hosting peer support groups weekly (NAMI, ChADD, Bipolar Foundation)
- Childcare and refreshments provided
- Collect data to inform potential improvements from family & youth perspective

MEDICATION CLINIC

MHSA Innovation Project Categories

- Increase access to care for underserved populations
- Introduce a new mental health practice

510 Youth to be Served Annually

- Via Psychiatrist placement in Pediatric Clinic
  - **100 children per year**
- Via Tele-psychiatry to 6 regions (12 sites)
  - **25 children/youth per site = 300 children per year**
- Via the Medication Clinic (central office)
  - **100 children per year**
- Injectable Medication Clinic
  - **10 children per year**

MEDICATION CLINIC

LIVE WELL SAN DIEGO

How this is different from similar sounding programs

Search Results

- **Seattle Children's PAL Program**
  - Telephone consultation to primary care
- **Massachusetts CAPAP**
  - Same + some face-to-face assessments
- **Teen Health Van of Stanford Children's Hospital**
  - Primary care, counseling, substance abuse care for teens with access to care problems
- **Children's Hospital Orange County**
  - Co-occurring clinic (medical and mental health) 2015

Search Results

- **CASES (NYC) The Nathaniel Clinic**
  - Juvenile Justice youth
  - Integrated primary care, specialty mental health care, substance abuse care, legal services, benefit services
- **Patient Centered Mental Home**
  - Integrated primary care and mental health care
- **Gardner Health Services in San Jose**
  - Primary care with mental health
  - Multiple special services
  - Medi-Cal funded

MEDICATION CLINIC

MEDICATION CLINIC PROJECTED COST

Annual Budget: $ 1,936,636

Total Project Cost: $ 8,836, 362

Project Duration: 4.5 Years

Budget	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23 (Half year only)	Total
Salaries & Benefits	$ 1,400,880	$ 1,400,880	$ 1,400,880	$ 1,400,880	$ 700,440	$ 6,303,960
Operating Cost*	$ 287,847	$ 287,847	$ 287,847	$ 287,847	$ 143,924	$ 1,295,312
Indirect Cost	$ 274,909	$ 274,909	$ 274,909	$ 274,909	$ 137,455	$ 1,237,091
Projected Annual Budget	$ 1,963,636	$ 1,963,636	$ 1,963,636	$ 1,963,636	$ 981,818	$ 8,836,362
S&B Rate to Annual Budget	71%	71%	71%	71%	71%	71%
Operating Cost Rate to Annual Budget	15%	15%	15%	15%	15%	15%
Indirect Rate based on Annual Budget	14%	14%	14%	14%	14%	14%

* Operating Cost includes $100,000 Evaluation cost per year which is 5% of the total annual budget.

MEDICATION CLINIC

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)?

Proposed Motion

- **Proposed Motion:** The MHSOAC approves San Diego'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

Mental Health Services
Oversight & Accountability Commission

Request for Funding for Evaluation and Transparency Portal Projects

Brian R. Sala, Ph.D.
Fred Molitor, Ph.D.

Agenda Item 8
May 25, 2017

WELLNESS • RECOVERY • RESILIENCE

Outline

- Proposed Evaluation contracting activities:
  - Pilot classification study of FSPs in selected counties
  - Develop a statewide survey of the mental health needs/unmet needs of TAY
- Further support of Transparency Data Portal and Evaluation activities
  - Technical testing
  - Ongoing M&O

FSP Classification Pilot

- Objectives: Work collaboratively with selected counties to
  - refine and implement classification tool for FSP programs
  - demonstrate value of data for county-driven evaluation of FSP programming
  - Facilitate matching client partners to program types for statewide outcomes assessment

Transparency Data Portal and related IT Support

The MHSOAC has been pursuing a broad data transparency agenda over the last year. This agenda includes development of a data analytic environment and capacity, as well as a data portal.

Deliverable	Type	Estimated Not to Exceed	Status		
			Previously Approved	New Request	Future Request
Proposition 63 and MHSOAC Website consolidation	Project	$50,000	$50,000 Informatix		
MHSOAC Website ongoing maintenance	Ongoing	$110,000	$50,000 Informatix (FY16/17)	$60,000 (FY17/18)	
MHSOAC Data Portal & SAS infrastructure	Ongoing	$224,500	$139,500 iFish (FY15/16)	$85,000 (FY17/18)	
Fiscal Transparency M&O + RERs	Ongoing	$350,000	$250,000 iFish (FY16/17)	$100,000 (FY17/18)	
Full Service Partnership	Project	$250,000	$250,000 iFish (FY16/17)		
Programs, Providers and Services	Project	$475,000	$140,000 MHDATA (FY15/16) $250,000 iFish (FY16/17)		
Full-Service Partnership Pilot	Evaluation Project	$225,000		$225,000 (FY16/17)	
Fiscal Transparency v2.0	Project	$475,000	$250K iFish (FY16/17)		$225,000 (FY17/18)
Office Automation SharePoint Implementation	Project	$215,000			$100K (FY17/18) $65K (FY17/18)
Transparency Testing	Project	$50,000		$50K (FY17/18)	
Project Totals (less website consolidation)		**$1,515,000**	**$890,000**	**$275,000**	**$390,000**
Ongoing Totals		**$684,500**	**$439,500**	**$245,000**	
Grand Totals (+ website consolidation)		**$2,149,500 (+ $50,000)**	**$1,329,500 (+ $50,000)**	**$685,000**	**$390,000**

TAY survey development

Assessing Levels of Mental Health Need and Unmet Need among Transition Age Youth

Objectives:

Among general and/or within selected TAY (sub)populations, estimate MH:

1. Need overall and across racial/ethnic and other groups.
2. Unmet need across the continuum of services.

TAY Subpopulations

- Incarcerated youth who may receive services in jail or juvenile hall;
- Young military personnel;
- Students; and
- LGBTQ.

Research Findings

- Half of MH disorders begin before age 14.
- The median age of onset for many disorders occurs during the transition phase to adulthood.
- TAYs are an important population for targeting PEI services since their needs are more likely to be in the early stages.
- Previous studies have focused on adults and only on severe MH disorders.

Survey Methodology

- Probability-based sampling for general TAY population.
- Convenience or cluster sampling for TAY subpopulation(s).

Phase 1 Activities

Through expanded literature review and input from workgroup meeting:

- Identify TAY (sub)population.
- Develop questionnaire.
- Refine survey methodology.

Upon Completion of Phase 1

- Counties could use questionnaire as evaluation tool.
- Questionnaire could be used to assess need/unmet need among children, adults, or older adults.
- Periodic surveys could assess changes over time.
- Counties could support oversampling within their jurisdictions.

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.